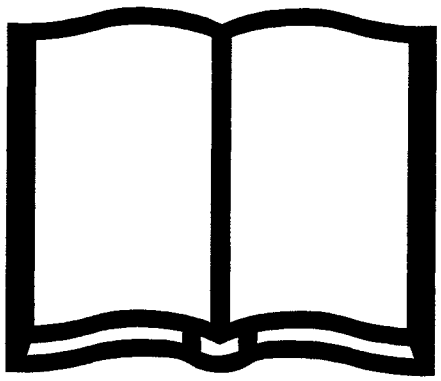
COUNTY OF SAN DIEGO
ADULT/OLDER ADULT MENTAL HEALTH SERVICES
DOCUMENTATION AND UNIFORM
CLINICAL RECORD MANUAL



JULY 2004

TABLE OF CONTENTS

Table of Contents (continued)

CLINICAL RECORD FORMS
ADULT MENTAL HEALTH SERVICES

Section 1	**Client Data**	
	Client Checklist	HHSA:MHS-112 (07/2004)
	Client Information Face Sheet	MHS-140
	Discharge Summary	HHSA:MHS-920 (06/29/2003)
Section 2	**Assessment**	
	Initial Screening	HHSA:MHS-922 (07/2003)
	Initial Mental Health Assessment	HHSA:MHS-912 (07/25/2003)
	Expedited Assessment	HHSA:MHS-991 (07/2004)
	Community Functioning Evaluation	HHSA:MHS-976 (12/2001)
Section 3	**Plans**	
	Client Plan	HHSA:MHS-975 (12/2001)
	Crisis/Recovery Plan	HHSA:MHS-116 (10/2002)
Section 4	**Notes**	
	Individual Progress Note	HHSA:MHS-925 (01/14/2004)
	Group Progress Note	HHSA:MHS-924 (01/14/2004)
	Progress Note – Other Services	HHSA:MHS-926 (01/14/2004)
	Medication Profile (Contract)	HHSA:MHS-913 (07/2004)
	Medication List (County)	HHSA:MHS-997 (07/2004)
	Medication Management (non-San D/Map) replaced 124	HHSA:MHS-928 (01/14/2004)
	Medication/Progress Note (San D/Map)	HHSA:MHS-125 (06/10/2004)
	Medication Prescription	HHSA:MHS-994 (05/25/2004)
	Global Assessment of Functioning Update Form	HHSA:MHS-999 (07/2004)
Section 5	**Medical**	
	Informed Consent for the Use of Psychotropic Medications	HHSA:MHS-005 (06/2004)
	Lab Results	
	Medical History Questionnaire	HHSA:MHS-911 (12/2001)
	Abnormal Involuntary Movement Scale (Optional)	HHSA:MHS-914 (06/2003)
	Vital Signs/Weight/Height Record (optional)	HHSA:MHS-909 (06/2003)
Section 6	**Administrative/Legal**	
	Agreement for Services	HHSA:MHS-119 (06/29/2003)
	All other consents/authorizations	
	Advance Directive	
	Client Questionnaire	HHSA:MHS-916 (06/2003)
Section 7	**Correspondence**	
	Correspondence Received	
	Documentation of correspondence requested	
Section 8	**Previous Treatment**	
Section 9	**Appendix**	
	Materials for County Operated Clinics	
	Authorization to use or disclose Protected Health Information	HHSA: 23-07 (04/03)
Section 10	**San D/Map Programs**	
	Client Self-Report	*not numbered
	Clinician Symptom Rating	HHSA:MHS-918 (07/2004)
Section 11	**Case Management**	
	File Chart Order	
	Agreement for Services	HHSA:MHS-864 (06/2003)
	Client Financial Information	HHSA:MHS-862 (06/2003)
	Discharge Summary	HHSA:MHS-860 (06/2002)
	Face Sheet	HHSA:MHS-861 (06/2003)
	Transfer/Case Manager Discharge Checklist	HHSA:MHS-863 (06/2003)

UNIFORM CLINICAL RECORD AND DOCUMENTATION SYSTEM

A "Uniform Clinical Record and Documentation System" means that whenever possible, the forms used in our system of care will be the same. Forms used within each service will be the same.

The forms are not intended to be a substitute for clinical skills or interview structure, and do not include all variables, which should be assessed. All prompts mentioned on the forms should be assessed and documented, but what the clinician observes or asks is not intended to be limited by what is printed on the forms. The clinician's judgment is the final determinant of additional documentation.

PURPOSE OF UNIFORM CLINICAL RECORD AND DOCUMENTATION SYSTEM

- Serve as a vehicle for documentation of the client's condition, planned services and response to services provided.
- Document coordination of services with other health professionals providing care to the client.
- Assist in protecting the legal interests of the client, the program and the clinicians.
- Provide data for use in planning future services, evaluating outcomes, continuing education and research.

The importance of maintaining a comprehensive, detailed and uniform clinical record and documentation system cannot be overemphasized. The clinical record stores the knowledge concerning the client and his/her care. The content of the clinical record is developed as a result of the interaction of the mental health care team who use it as a communication tool. To be complete, the clinical record must contain sufficient information to identify the client clearly, support the diagnosis, justify the treatment, record: observations, plans, outcomes and document the interventions and the client's response accurately. The record is the mechanism for continuity among members of the client care team, both within and across encounters.

The team is an interdisciplinary group composed of physicians, nurses, social workers, psychologists and other health care professionals. They communicate about their findings, observations, opinions and treatment of the client through their entries in the record. It is necessary that there be prompt recording of observation, treatment and care by all who contribute to the care of a client.

Uniformity of the clinical record facilitates access to necessary client documentation and simplifies review of records. The clinical record is potentially one of the most important and persuasive items of evidence available in counteracting a client's allegations of medical negligence. It is also used for planning future services, evaluating outcomes, collecting data for research, training, and is fundamental to payment of claims and subsequent verification of claims.

GENERAL GUIDELINES OF RECORD KEEPING

1. Medical Record documentation is required to record pertinent facts, findings, observations about an individuals health, history, including past and present illness, examinations, tests, treatments and outcomes.
2. There shall be a unit record system. That is, all records from a service source relating to one client shall be filed together. A complete picture of the client is then available to everyone contributing to the client's continuum of care.
3. Write legibly so that all entries in all clinical records are clear and readable. All information must be **legible** and document, for each date of service, the following information:
   - The billed services have been rendered
   - The services were appropriate for the patient's condition
   - The services meet reasonable standards for medical care
4. Once an entry has been made, never erase, over-write, white-out, or try to ink out any part of it. In case of an error, draw a single line through the incorrect information, write the date, and your initials next to the "lined-through", material.
5. Use black ink pens. Never use water base (felt) pens or pencils when writing in a clinical record.
6. Draw a diagonal line through all blank lines left on a page when documentation is begun on a new page.
7. Use only the approved list of abbreviations when charting.
8. Use precise, behavioral descriptions.

   Imprecise – Appears depressed.

   Precise – Crying, poor eye contact, states she is not sleeping because she is worried about her illness.
9. The report of laboratory work and radiological examinations must bear the date the physician reviewed the report and his/her initials.
10. Case conferences should be entered into the clinical record. If you fail to comply with or reject a consultant's advice, your justification for this must be recorded.
11. Record incidents or adverse effects of treatment/medications of a client verbatim:

    Incorrect: Client apparently fell when leaving day care room.

    Correct: Client states "tried to get up, tripped and hit my head on corner of table in day room."

12. Each page must bear the client's full name, medical record number for county programs or S# for non-county programs, and program name. For client's name, use the following order for documentation: Last, First, Middle Initial. For first name, use proper name only and not a nickname.

13. Each progress note must be accompanied by the date of the contact and the signature and discipline of the person making the entry. The signature must include the clinician's first name or initial and last name.

14. Additions to an entry already made must be made separately, and signed and dated. Such entries should be labeled "addendum."

15. All entries into a client record must be signed, dated and include the professional license and/or degree, and/or job title on each recorded service.

16. All work documented in the client record by para-professionals, unlicensed personnel, such as mental health workers, must be within the scope of their job description and should be under the supervision of responsible licensed mental health professional staff.

17. When documenting a late entry, use the date of the documentation in the column and label "late entry for (date)."

18. All entries made by volunteers/students must be co-signed by a supervising licensed mental health professional. Volunteers/students cannot make entries in the medical record unless they have authorization from program administration.

19. Communications from other people that are in the interest of the client, or otherwise important to the treatment process, may be filed in the client record in the correspondence section without countersignature.

20. Signatures – must be legible.

    Signatures that are not complete (see #15) and/or are not legible must be accompanied by a stamped signature.

21. In all instances the medical record must indicate that the client has a psychiatric illness and/or is demonstrating emotional behavioral symptoms sufficient enough to interfere with normal functioning, and must include the time spent in the (psychotherapy) encounter and that cognitive skills, such as behavior modification, insight and supportive interactions, and discussion of reality were applied to produce therapeutic change.

Documentation Requirements	Asst	Asst Inter	Individ	Individ	Individ	Individ Inter-active	Individ Inter-active	Individ Inter-active	Fam Ther	Fam with Individ	Multi-family	Group	Group Inter-active	Other Med Service	Pharm Mngmt	Med monitor; drug change	MD Educ	Nurse med service	Rehab	TBS	Inter-pret Data to Others	Rec Review	Crisis Interv'n	Collateral	Case Mgmt
	90801	90802	90804	90806	90808	90810	90812	90814	90846	90847	90849	90853	90857	H2010	90862	M0064	99078	H2010	H2015	H2019	90887	90885	H2011	H2015	T1017
	801	802	804	806	808	810	812	814	846	847	849	853	857	860	862	864	878	382	535	313	878	885	370	310	501
	701	702	704	706	708	710	712	714	746	747	749	753	757	760	762	764	778	388	Rehab	TBS	778	785	371	311	512
Date of service	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Name of Client	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Procedure Code	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Diagnosis Code	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Emotional Symptoms/Complaints	●	●	●	●	●	●	●	●		●	●	●	●	●	●	●		☺	●	●			●		☺
Face-to-face time	●	●	20-44	45-74	=75>	20-44	45-74	=75>	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Location	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
History																									
History of Present Illness	●	●							☺	☺	☺			☺	☺	☺		☺				☺	☺	☺	☺
PFSH (Past, Family, Social)	●	●							☺	☺	☺			☺	☺	☺		☺				☺	☺	☺	
Historical Response to Treatment	●	●							☺	☺	☺			☺	☺	☺		☺				☺	☺	☺	☺
Client Appearance	●	●	●	●	●	●	●	●		●	●	●	●	☺	●	●	☺	☺	●				●		☺
Precipitators/Environmental Attributes	●	●	●	●	●	●	●	●	☺	●	●	●	●	☺	☺	☺	☺	☺	●	☺			●	☺	☺
Level of Cognitive Capacity	●	●	●	●	●	●	●	●		●	●	●	●	☺	●	●	☺	☺	●	☺			●	☺	☺
Potential for harm/Disposition/Tendencies	●	●	●	●	●	●	●	●		●	●	●	●	☺	●	●	☺	☺	●	☺			●	☺	☺
Medical Evaluations/Impressions	●	●																				●	●		
Medical Examination/ROS	●	●																					☺		
Medical Tests Review	●	●																				☺	☺		
Progress/Response to Treatment			●	●	●	●	●	●	●	●	●	●	●	☺	●	●	●	☺	●	●		☺	●		☺
Interactive activities		●				●	●	●	☺	☺	☺	☺	●	☺	☺	☺	☺	☺	☺	☺	☺		☺	☺	☺
Immediate service intervention required	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺			●		☺
Counseling/therapy/interventions provided	●	●	●	●	●	●	●	●	●	●	●	●	●	☺	●	☺	●	☺	●	●	●		●	●	●
Plan of Care/Changes to Plan of Care	●	●	●	●	●	●	●	●	●	●	●	●	●	☺	●	●	☺	☺	●	●	☺	●	●	●	●
Other resources of information	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	●	☺	●	●	☺
Medications	●	●							☺	☺				●	●	●	☺	☺					☺		
Effects of Medications														●	●	●	☺	☺					☺		
Side-effects experienced														●	●	●		☺					☺		
Medication Education Administered														☺	●	●	●	☺			☺		☺		
Referrals	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺	☺
Date Documentation Written	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Signature of Provider of Service	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

● Required element
☺ Recommended, if applicable
Blank Not a required element

CLIENT DATA

Client Checklist

WHEN: The Client Checklist Form is placed in the front of the chart at the time of admission to services. Each item on the list is signed off and dated upon the completion of the requirement. If an item is not applicable, N/A should be written in the signature line and date the entry.

ON WHOM: All clients receiving services at the time of admission to a program.

COMPLETED BY: Any staff.

MODE OF COMPLETION: Legibly handwritten signatures and dates on the HHSA:MHS-112.

REQUIRED ELEMENTS: All applicable items.

Client Checklist

Signature and date required for all applicable items when item is completed. If item is not applicable, write N/A and date that entry. ⇨	**Signature**	**Date**
Program's Notice of Privacy Practices given to client		
County Mental Health Plan Notice of Privacy Practices given to client		
Language/interpretation services offered		
Program's services, activities, performances, expectation provided		
Agreement for Services (HHSA:MHS-119)		
Financial/UMDAP/Medi-Cal		
Program rules and regulations given		
Medical History Questionnaire		
Discharge criteria and procedures reviewed		
Other (ex. Client asked to bring in current medications)		
Beneficiary Handbook provided and described		
Client informed of Freedom of Choice		
Grievance/Appeal process reviewed		
Tour of facility provided		
Authorization to use or disclose Protected Health Information		
Client Information Face Sheet (MHS140)		
Initial Mental Health Assessment		
Community Functioning Evaluation		
Client Plan		
Care Coordinator Assigned		
Voter Registration		
Informed of right to have Advance Directive ☐ Yes ☐ No Does client have an executed Advance Directive? ☐ Yes ☐ No If yes, informed client of right to have Advance Directive placed in medical record ☐ Yes ☐ No		

CLIENT INFORMATION FACE SHEET

WHEN: This form is generated by Insyst System and updated as necessary.

ON WHOM: All individuals seeking services.

COMPLETED BY: Any service delivery staff participating in the admission process.

MODE OF COMPLETION: Entry of data into Mental Health Management Information System.
Printed form title: MHS-140.

REQUIRED ELEMENTS: Identifying client information, complete diagnosis with DSM-IV-TR codes, psychiatrist and primary therapist.

Client Information Face Sheet

Report MHS 140
Run Date: 9-OCT-2002

CONSUMER INFORMATION

Name:	Justin Thyme	Number	1	Birth date	20-Sep-1990	Age	12
Address	123 SAM ST	SSN	999-99-9991	Sex	M		
	SAN DIEGO, CA 92107	Other ID #:	456789	Language	Mien		
Phone	(619) 555-1212	Marital:	Married	Education:	Grade 11		
Staff:	FEELGOOD, IWANNA (000)	Disability:	None	Ethnicity:	White	Hispanic Origin:	Hispanic
Aliases:	JOE B. SHMOE, JONNIE SMITH, DANNY JONES						
RP Owes:	$0.00	Medicaid	Y11999:	Last Eligibility:	1/2000		

Insurance: MEDICARE PT A PRIMARY BC (9997), MEDICARE PT B PRIMARY-TO (9999), PRINCIPAL FINANCIAL GROUP (45) PACIFIC CARE (256)

SIGNIFICANT OTHERS

Name:	Relation	Home Phone	Work Phone	Address
Thyme Sr., Justin	Father	(619) 555-1212	(760) 333-3333	555 SE ANZA ST, apt. 23-c, San Diego, CA 9212:
Blow, Joe	Other	( ) -	(619) 123-4567 x8910	
Thyme, Siesta	Stepmother	(619) 853-1515	(760) 222-4444	1130 S NERD DR, APT 111, SAN DIEGO, CA 92111

CLINICAL HISTORY

RU	Opening	Closing	Primary Diagnosis	Clinician	Physician	Total Units	Last Service	Lega Stat
-------OPEN EPISODES----------								
UBH	22-JUN-2002		295.70	STAFF, GENERAL		7	21-AUG-2002	W515(
TEST - IP	6-JUN-2001					4		
-------CLOSED EPISODES----------								
UBH	18-JUN-2002	19-JUN-2002	296.50	SHUMAN, JUDY		1	19-JUN-2002	W600(
EPU-OP -ADLT	7-DEC-2001	7-DEC-2001	296.20			0		W600(

****
Confidential Information
****

DISCHARGE SUMMARY

WHEN: This form must be completed within 14 days of discharge for clients seen five or more times.

ON WHOM: Clients discharged from Mental Health Services, or clients not seen for three months, unless the clinician has documented the reason for absence and it is reasonably expected that the client will return within six months.

COMPLETED BY: Staff delivering services within scope of practice. Must be signed by Physician, licensed/waivered Psychologist, licensed/registered/waivered social worker, licensed/registered/waivered Marriage Family Therapist or a Registered Nurse.

MODE OF COMPLETION: Legibly handwritten, typed or word processed on form HHSA:MHS-920.

REQUIRED ELEMENTS: Description of the most current five axes diagnosis, reason for admission, reason for termination, assessment results, course of treatment, response to treatment, discharge medication, prognosis, discharge plan, signed and dated by the clinician.

BILLING: May only bill when connected to a direct client service. If completed on same day as discharge visit with the client, include discharge summary preparation time in billing for this service in total time.

Date of Admission: _____ Discharge Date: _____

Diagnosis at Discharge – DSM – IV-TR

Code

Axis I: _____ _____

_____ _____

Axis II: _____ _____

Axis III: _____ _____

Axis IV: _____ _____

Axis V: _____ _____

---

* CAUTIONS/DANGERS/ALLERGIES*

_____

Reason for Admission: (Presenting Problem) _____

_____

_____

Reason for Termination: _____

_____

_____

Assessment Results; Course of Treatment and Response to Treatment: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

County of San Diego
Health and Human Services Agency
Mental Health Services

DISCHARGE SUMMARY

Client: _____

MR/Client ID #: _____

Program: _____

Assessment Results; Course of Treatment and response to treatment – (Continued from front): _____

Treatment Complete ☐ Yes ☐ No

History or Propensity for Violence, Fire setting, Criminal Activity, Sex Offences, or Suicide Attempts: _____

Discharge Medication: (Name/dose/frequency/amount dispensed)_____

Prognosis: (6 month – 12 month, present level of functioning) _____

Discharge Plan/recommendations/disposition: (Aftercare plan, living arrangements)_____

Referred to:_____ Appointment Date:_____ Time:_____

Signature
Clinician:_____ Title:_____ Date: _____

Co-Signature
Clinician:_____ Title:_____ Date: _____
(If Required)

County of San Diego
Health and Human Services Agency
Mental Health Services

DISCHARGE SUMMARY

Client:_____

MR/Client ID #:_____

Program:_____

ASSESSMENT

INITIAL SCREENING

*** NOTE:** Use of this form is optional for Contract Providers.

WHEN: During contact, immediately thereafter, or as soon as possible following contact with the client.

ON WHOM: Form HHSA:MHS-922 should be completed on all un-"opened" clients when there is a significant issue, when the client is likely to come in or when the client is referred to another agency. Not required if formal chart is opened immediately.

COMPLETED BY: Clinical staff participating in the client contact.

MODE OF COMPLETION: Legibly hand written, typed or word-processed on form HHSA:MHS-922.

REQUIRED ELEMENTS: All elements should be completed. The following four domains are mandatory: presenting problem; current medication; current substance abuse; and current potential for harm. The narrative section should be as complete as possible and can span multiple contacts. The back section, (Narrative Con't), can be used as any normal progress note and should be dated and signed by the person completing the narrative.

BILLING: Bill to MAA code 451

NOTE: This form may be used as a "stand alone" record.

Staff Member: _____ **Date:** _____

Client Name: _____
Last **First** **Middle**

Address: _____
Apartment **City/State** **Zip Code**

Phone: ( ) **Age:** **Date of Birth:** **Soc. Security #** _____

Referral Source:

Name: **Address** **Phone No.**

Financial: **Insurance** ☐ **Yes** ☐ **No** **Medi-Cal:** ☐ **Yes** ☐ **No** **Medicare** ☐ **Yes** ☐ **No**
Income: **$** **Veteran** ☐ **Yes** ☐ **No** **Parole** ☐ **Yes** ☐ **No**

Instructions: **The following four domains are mandatory. Additional narrative may be added on page 2.**

Presenting Problem:

Current Medications:

Current Substance Abuse:

Current Potential for Harm:

Service Eligibility Criteria Met: Yes ☐ **No** ☐ **Uncertain** ☐ **If NO for Medi-Cal Notice of Action Issued: Yes** ☐ **No** ☐

Orientation Meeting (if applicable) Date: _____ **Time:** _____

Mental Health Assessment Appt Date: _____ **Time:** _____ **Therapist:** _____

Psychiatric Evaluation Appt Date: _____ **Time:** _____ **MD** _____

Continued (If YES, check) ☐

Narrative

Progress Notes {Date and Sign each entry}

Completed by: _____ _____ _____ _____

Signature | Title | Date | Time Spent

Case Number (generated by MHIS): _____
Date Case Opened: _____
Provider No.: _____
Activity No.: _____

SEX ☐ 1 Male ☐ 2 Female

AGE
☐ 1 0-17 yrs.
☐ 2 18-54 yrs.
☐ 3 55 + yrs.

ETHNIC GROUP
☐ 1 White
☐ 2 African/American
☐ 3 Hispanic
☐ 4 Native American
☐ 5 Chinese
☐ 6 Japanese
☐ 7 Filipino
☐ 8 Indochinese
☐ 9 Other:

PREFERRED PRIMARY LANGUAGE
☐ 1 English
☐ 2 Spanish
☐ 3 Other:

LIVING ARRANGEMENTS
☐ 1 Alone
☐ 2 Family/Relative
☐ 3 With Others
☐ 4 Community Facility
☐ 5 Homeless
☐ 6 Other:

EMPLOYMENT STATUS
☐ 1 Employed
☐ 2 Unemployed
☐ 3 Retired
☐ 4 SSI Disability
☐ 5 Other

Case Completed	☐ Y	☐ N
If case completed: Problem Resolved	☐ Y	☐ N
Appropriate Referral made	☐ Y	☐ N
Total Number of Contacts:		

PRIMARY PROBLEM (Check only 1 in each category)

MENTAL ILLNESS
☐ 1 Mood Disorder
☐ 2 Thought Disorder
☐ 3 Anxiety Disorder
☐ 4 Organic Disorder
☐ 5 Other:

SUBSTANCE ABUSE (within 6 months)
☐ 1 Drugs
☐ 2 Alcohol
☐ 3 Poly-substance
☐ 4 None

SITUATIONAL CRISIS
☐ 1 Homeless
☐ 2 Loss/Grief
☐ 3 Family/Parenting
☐ 4 Med. Non-Compliance
☐ 5 Other:
☐ 6 None:

OTHER RISK FACTORS (Multiple entries allowed)
☐ 1 Suicidal
☐ 2 Homicidal/Assaultive
☐ 3 Sexual Trauma
☐ 4 Abuse
☐ 5 Domestic Violence
☐ 6 None

DISPOSITION
☐ 1 Critical Care/EPU
☐ 2 Frontline
☐ 3 CCTC
☐ 4 Crisis Residence
☐ 5 Homeless Team
☐ 6 Senior Team
☐ 7 Other Mental Health – County/Contract
☐ 8 Private Hospital
☐ 9 Mental Health Community
☐ 10 Social Service Program
☐ 11 Legal/Law Enforcement
☐ 12 Medical
☐ 13 Drug/Alcohol Program
☐ 14 Self Help/Support Group
☐ 15 No referral/Crisis Resolved

INITIAL MENTAL HEALTH ASSESSMENT

WHEN: Within one month after the first planned service with updates as clinically appropriate. When updating, initial and date the changes then sign the bottom of the form. Insert Progress Note with any additional information in assessment section of medical record. If applicable, refer to Initial Screening for initial contact information. *

ON WHOM: All individuals receiving services beyond one month.

COMPLETED BY: Staff delivering services within scope of practice. Must be signed by Physician, licensed/waivered Psychologist, licensed/registered/ waivered social worker, licensed/registered/waivered Marriage Family Therapist, or a Registered Nurse.

MODE OF COMPLETION: Legibly handwritten, typed, or word processed on form HHSA:MHS-912.

REQUIRED ELEMENTS: Description of presenting problem and psychiatric symptoms, psychiatric history, medical history, mental status exam, most current five axes diagnosis or a documented plan to obtain one.

BILLING: Write a progress note stating date started, completed, or reviewed. Note in the column the procedure code and the total number of minutes. To calculate total numbers of minutes include preparation time, interview time, and documentation time. Also note in the column the number of minutes spent solely as face-to-face time (direct time).
For Example:Total: 120 Minutes
Direct: 60 Minutes. Refer to billing record for appropriate procedure code.

EXCEPTIONS: This form must be completed on every new adult client admitted. If there is a recent existing assessment done within San Diego County Adult Mental Health system of care that was created within the last 90 days that, in your clinical opinion, is appropriate to use, you may review and update it with the client, and document this information on the Expedited Assessment (HHSA:MHS-991).

NOTE: A "Progress Note" may be attached to complete the narrative sections, if additional space is required.

- Initial Screening beginning domains

Assessment Date:_____

PRESENTING PROBLEM: (Identifying Data/Chief Complaint and History of Present Illness. Summarize client's request for services including client's most recent baseline and the subjective description of the problem. Include precipitating factors that led to deterioration, and describe events in sequence leading to present visit. Include objective impairing behaviors, including experiences and stigma, if any, and prejudice and client's requests/needs).

PAST PSYCHIATRIC HISTORY: (Previous mental health treatment; in chronological order; where, when, for how long. Include dates/providers related to any prior psychiatric treatment, history, traumatic and/or significant events, include immigration history, and impact if any. Describe most recent periods of stability and the characteristics of those periods).

FAMILY HISTORY:

Any family members with a history of any of the following? (Please, check all that apply):

	Depression	Schizophrenia	Bipolar	Substance Use	Suicide	Other	Effective Treatments
Parent							
Sibling							
Children							
Aunt/Uncle							
Grandparent							

CULTURE/FAMILY and RECOVERY POTENTIAL:

Birth place: ( )San Diego ( )USA ( )Other (fill in birth place and year moved to USA): _____

Language of choice for therapy: ☐English ☐Spanish ☐Vietnamese ☐Other(fill in Language) _____

Ethnicity: ☐ Latino/Hispanic ☐ African American ☐ Asian/Pacific Islander (fill in): _____

☐ White ☐ American Indian ☐ Other (fill in): _____

Culture specific symptomatology/explanations for behavior (May reference Appendix I of DSM-IV-TR) _____

Family/Community Support System- (Describe it, including alternative relationship support, if any for mental health and/or substance use. Who is supportive? Community groups, e.g. AA/NA).

Socio-Economic Factors: (Educational achievement, occupation, income source and level).

Religious/Spiritual Issues: (Is R/S important in your life? If yes, is it a source of strength in your recovery process? Describe how/who: persons, practices).

ASSETS/STRENGTHS: (What abilities or skills do you have that you would choose to develop during your recovery? What new ones might you choose to develop? Describe strengths that contributed to recent treatment successes, sobriety, etc).

MEDICAL HISTORY: (Indicate any significant medical history related to client's current mental health or substance use condition, including dates/providers related to prior treatment, as well as client's adjustment to co-occurring disabilities).

Current Medication(s)	Dose	Frequency	Taken as Prescribed?
			☐YES☐NO
			☐YES☐NO
			☐YES☐NO
			☐YES☐NO

ALLERGIES AND ADVERSE MEDICATION REACTIONS:

☐ NKA(s)

☐ Other (s)_____

HEALING AND HEALTH: (Alternative healing practices/beliefs. Apart from mental health professionals, who-- or what-- helps you deal with disability/illness and/or to address substance use problems? Describe):

NAME OF CURRENT PRIMARY CARE PHYSICIAN:

May we consult? ☐Yes ☐No **Date Last Seen:** _____ **Release of Information Form:** ☐Yes ☐No

_____

Name Address Phone number (including area code)

CLIENT'S HOSPITAL OF CHOICE:

_____

Name Address Phone number (including area code)

SUBSTANCE USE INFORMATION Indicate if no history of use ☐ History unknown ☐

(Describe the most recent baseline and characteristics in terms of symptoms, functioning, substance use, treatment, successful interventions, and factors (in sequence) that led to present deterioration. Identify periods of abstinence or minimal use of substances):_____

_____

_____

Type:	Date of Last Use	Amount of Last Use	Frequency and Amount of Use	Length of Time Using	Age of First Use

MENTAL STATUS EXAM:

Level of Consciousness:	☐Alert	☐Lethargic	☐Stuporous			
Orientation:	☐Person	☐Place	Time ☐Day ☐Month ☐Year		☐Current Situation	☐None
Appearance:	☐Clean	☐Well-Nourished	☐ Malodorous	☐ Disheveled	☐ Malnourished	☐ Reddened Eyes
Speech:	☐Normal	☐Slurred	☐Loud	☐Pressured	☐Slow	☐Mute
Thought Process:	☐Coherent	☐Tangential	☐Circumstantial	☐Incoherent	☐Loose Association	
Behavior:	☐Cooperative	☐Evasive	☐Uncooperative	☐Threatening	☐Agitated	☐Combative
Affect:	☐Appropriate	☐Blunted	☐Flat	☐Restricted	☐Labile	☐Other
Intellect:	☐Normal	☐Below Normal	☐Paucity of Knowledge	☐Vocabulary Poor	☐Poor Abstraction	☐ Uncooperative
Mood:	☐Euthymic	☐Elevated	☐Euphoric	☐Depressed	☐Anxious	☐Irritable
Memory:	☐ Normal	☐ Poor Recent	☐ Poor Remote	☐Inability to Concentrate	☐ Confabulation	☐Amnesia
Judgment:	☐ Normal	☐Poor	☐Unrealistic	☐Unmotivated	☐Uncertain	
Motor:	☐ Normal	☐Decreased	☐Agitated	☐Tremors	☐Tics	☐Repetitive Motions
Insight:	☐ Normal	☐Adequate	☐Marginal	☐Poor		

Note: A narrative mental status exam may be done on a progress note, in lieu of above.

Visual Hallucinations: ☐No ☐Yes Specify:_____

Auditory Hallucinations: ☐No ☐Yes Specify:_____

Delusions: ☐No ☐Yes Specify:_____

Other Information (optional):_____

POTENTIAL FOR HARM (Include risk factors, e.g. chronic illness, recent loss of job, age)

Current SI ☐ No ☐ Yes Specify plan: method, vague, passive, imminent_____

Access to means ☐ No ☐ Yes Specify_____

Previous Attempts ☐ No ☐ Yes Specify_____

Client Contract for Safety ☐ No ☐ Yes Specify in Progress Notes_____

Current HI ☐ No ☐ Yes Specify Plan: vague, intent, with/without means_____

Identified Victim ☐ No ☐ Yes Name and contact information_____

☐ No ☐ Yes Tarasoff warning _____

Client No Harm Contract ☐ No ☐ Yes Specify in Progress Notes_____

History of Violence ☐ No ☐ Yes Specify Type: past, current_____

History of Domestic Violence_____

History of Abuse ☐ No ☐ Yes Specify Type: past, current_____

Abuse Reported ☐ No ☐ Yes

Probation Officer Contact Info:

Name Address Phone (including Area Code)

CONVICTION OF FELONY AND JAIL TIME ☐ No ☐ Yes

What was the conviction for? Length of jail time?

DSM IV DIAGNOSIS: Impairment/Disability Use DSM-IV-TR Codes. Indicate (P) – Primary and (S) – Secondary	**Enter P in front of primary**	**DIAGNOSTIC CODE**
AXIS I		
AXIS I		
AXIS I		
AXIS II		
AXIS III Relevant Medical Conditions:		
AXIS IV Psychosocial and Environmental Problems:		
AXIS V Current GAF: Highest in Past Year:	**COD:** ☐Yes ☐ No	

INTERPRETIVE SUMMARY: (Justification for diagnosis and medical necessity. Summarize and integrate all information gathered from other sources to render clinical judgments regarding intensity, length of treatment and recommendations for services. Clearly state those emotional or behavioral symptoms that interfere with normal functioning. Include evaluation of client's ability and willingness to solve the clients presenting problems, addressing both mental health and substance issues from an integrated perspective).

Medical Necessity Met: ☐ Yes ☐ No NOA Issued: ☐ Yes ☐ No (Medi-Cal Clients only)

REHABILITATION/RECOVERY/RECOMMENDATIONS: (List in-house clinical services as well as names of agencies/clinicians currently being received or recommended.)

1.☐Assisted Living Services	7. ☐Employment Services	13.☐RAP Plan
2.☐Community Services	8. ☐Group Therapy	14.☐Recovery Programs/Socialization Services
3.☐ Case Management Services	9. ☐Housing Services	15.☐Substance Abuse Program (note level of care)
4.☐ Crisis Residential/Hospitalization	10.☐Individual Therapy	16.☐Support Group
5.☐Day Rehabilitation	11.☐Medical Treatment	17.☐Other
6.☐Education/Support	12.☐Medication Management	

Number and explain below:

_____ ☐Current_____
_____ ☐Proposed Referral_____
_____ ☐Current_____
_____ ☐Proposed Referral_____
_____ ☐Current_____
_____ ☐Proposed Referral_____
_____ ☐Current_____
_____ ☐Proposed Referral_____
_____ ☐Current_____
_____ ☐Proposed Referral_____

Completed by: _____ _____ _____ _____
Signature Title Date Time Spent

Co-signature: _____ _____ _____
(if required) Signature Title Date

Client:_____

MR/Client ID #:_____

Program:_____

EXPEDITED ASSESSMENT

WHEN: May use as "bridge" when existing full assessment has been done within previous 90 days within San Diego County Adult System of Care, that in your clinical opinion, is appropriate to use. You may review and update that document via this form.

ON WHOM: All individuals receiving services beyond one month.

COMPLETED BY: Staff delivering services within scope of practice. Must be signed by Physician, licensed/waivered Psychologist, licensed/registered/waivered social worker, licensed/registered/waivered Marriage Family Therapist or a Registered Nurse.

MODE OF COMPLETION: Legibly handwritten, typed, or word processed on form HHSA:MHS-991.

REQUIRED ELEMENTS: The clinician must complete all sections of the form, sign, indicate his/her discipline and date the form.

BILLING: Write the Expedited Assessment and complete the procedure code column with appropriate procedure code (from billing record) and the time column. Note in the column the procedure code and the total number of minutes. To calculate total numbers of minutes include preparation time, interview time, and documentation time. **Also** note in the column the number of minutes spent solely as face-to-face time (direct time).

For Example: Total 120 Minutes
Direct 60 Minutes

Date/ Procedure Code	Face to face time/total time in minutes/ Location *	Expedited Assessment **Refer to Previous Assessment of:** Date:_____ Assessor:_____ **Presenting Problem:**

Current Medication:
Current Substance Abuse:
MSE:
Current Potential for Harm:

Diagnosis: Use DSM-IV Codes.	**Impairment/Disability** Indicate (P) – Primary and (S) – Secondary	Enter P in front of Primary	Diagnostic Code
Axis I: P			
Axis I: S (COD Information)			
Axis II:			
Axis III: Relevant Medical Conditions:			
Axis IV: Psychosocial and Environmental Problems:			
Axis V: Current GAF:	**Highest in Past Year:**		
Interpretive Summary:			

* Note: Services are clinic based unless otherwise noted.

Completed by: _____ _____ _____
Signature Title Date

Co-signature: _____ _____ _____
(if required) Signature Title Date

MENTAL HEALTH ASSESSMENT UPDATE

WHEN: Up to 30 calendar days prior to the yearly anniversary of the current episode opening date, or more often if clinically indicated.

ON WHOM: All individuals receiving mental health services beyond one year. This includes individuals who are "meds only".

COMPLETED BY: Staff delivering services within scope of practice. Must be signed by Physician, licensed/waivered Psychologist, licensed/registered/waivered social worker, licensed/ registered/waivered Marriage Family Therapist, or a Registered Nurse.

MODE OF COMPLETION: Legibly handwritten, typed, or word processed on form HHSA:MHS-940 Mental Health Assessment Update.

REQUIRED ELEMENTS:

- Identifying Client Information
- Current Symptoms & Functioning/Current Services/ Frequency of Services
- Changes to Family/Support System/Socio-Economic/ Religious/Spiritual/Cultural
- Current Risk Assessment
- Co-Occurring Substance Use Update
- Current Medications
- Medical Update/Health Issues Last Year
- Mental Status Exam
- DSM IV-TR Diagnostic Update*
- Interpretative Summary
- Annual Client Notification Requirements
- Signature/licensure/title
- Co-signature, if required

BILLING: The Mental Health Assessment Update is billed to CPT 90801. Document that the service was provided on the appropriate progress note.

***NOTE:** When a revision is made to the DSM-IV-TR diagnosis it must be entered into InSyst.

I. **IDENTIFYING CLIENT INFORMATION** **Admission Date:** _____ **Today's Date:** _____

Age:_____ **Race/Ethnicity:**_____ **Marital Status:**_____ **Gender:** ☐Male ☐Female

Language Choice for Services: ☐ English ☐ Spanish ☐ Vietnamese ☐ Other (fill in Language)_____

Source of Income: ☐ SSI ☐ SSA ☐ GR ☐ None ☐ Other: _____ Amount:_____

Insurance: ☐ Medi-Cal ☐ Medicare ☐ Healthy San Diego/Private:_____ ☐ None

Employment/Vocational/Educational Status:_____

_____

Housing Status: (type, number in household, housing at risk, with roommate/family, etc.):_____

_____

Other Legal/Case Management Status:

Case Manager: ☐ Yes ☐ No
Name: _____
Payee: _____

Conservator: ☐Yes ☐No Type:_____

Probation/Parole Officer: ☐ Yes ☐ No
Name: _____
Other Legal Issues: _____

_____

Other Care Providers:_____

II. **CURRENT SYMPTOMS & FUNCTIONING/CURRENT SERVICES/FREQUENCY OF SERVICES**

_____

_____

_____

_____

_____

_____

_____

Hospitalizations/Crisis Program Admissions In Last Year: (list and describe):_____

_____

_____

III. **CHANGES TO FAMILY/SUPPORT SYSTEM/SOCIO-ECONOMIC/RELIGIOUS/SPIRITUAL/CULTURAL**

_____

_____

_____

IV. **CURRENT RISK ASSESSMENT** (SI, HI, domestic violence, child abuse, elder/dependent abuse, threats or violence, grave disability)

☐ No current risks/potential for harm

_____

_____

_____

V. CO-OCCURRING SUBSTANCE USE UPDATE **CO-OCCURRING DISORDER (COD)** ☐Yes ☐No

(For last year, describe factors that led to use, treatments, interventions, and periods of sobriety) _____

_____

_____

_____

Type(s) used in last year:	Length of Use	Typical Amount of Use	Pattern/Frequency of Use	Mode of Ingestion	Date of Last use
_____	_____				
_____	_____				
_____	_____				
_____	_____				

Cadre Programs only complete: Quadrant:_____ Stage of Change: **Psych:**_____ **Sub.:**_____

VI. CURRENT MEDICATIONS (name only) _____

_____

VII. MEDICAL UPDATE/HEALTH ISSUES LAST YEAR _____

_____

Primary Care Physician: _____ Phone:_____

Psychiatrist: _____ Phone: _____

Medical Hospitalizations: ☐ Yes ☐ No Explain:_____

VIII. MENTAL STATUS EXAM Note: A narrative mental status exam may be done on a progress note in lieu of below.

Level of Consciousness:	☐Alert	☐Lethargic	☐Stuporous			
Orientation:	☐Person	☐Place	Time ☐Day ☐Month ☐Year		☐Current Situation	☐None
Appearance:	☐Clean	☐Well-Nourished	☐ Malodorous	☐ Disheveled	☐ Malnourished	☐ Reddened Eyes
Speech:	☐Normal	☐Slurred	☐Loud	☐Pressured	☐Slow	☐Mute
Thought Process:	☐Coherent	☐Tangential	☐Circumstantial	☐Incoherent	☐Loose Association	
Behavior:	☐Cooperative	☐Evasive	☐Uncooperative	☐Threatening	☐Agitated	☐Combative
Affect:	☐Appropriate	☐Blunted	☐Flat	☐Restricted	☐Labile	☐Other
Intellect:	☐Normal	☐Below Normal	☐Paucity of Knowledge	☐Vocabulary Poor	☐Poor Abstraction	☐ Uncooperative
Mood:	☐Euthymic	☐Elevated	☐Euphoric	☐Depressed	☐Anxious	☐Irritable
Memory:	☐ Normal	☐ Poor Recent	☐ Poor Remote	☐Inability to Concentrate	☐ Confabulation	☐Amnesia
Judgment:	☐ Normal	☐Poor	☐Unrealistic	☐Unmotivated	☐Uncertain	
Motor:	☐ Normal	☐Decreased	☐Agitated	☐Tremors	☐Tics	☐Repetitive Motions
Insight:	☐ Normal	☐Adequate	☐Marginal	☐Poor		

IX. DSM IV-TR DIAGNOSTIC UPDATE

DSM-IV-TR DIAGNOSIS (P=Primary S=Secondary)	CO-OCCURRING DISORDER (COD): ☐Yes ☐No	DIAGNOSTIC CODE
AXIS I (P)		
AXIS I (S or COD)		
AXIS I (S)		
AXIS II		
AXIS III Relevant Medical Conditions:		
AXIS IV Psychosocial and Environmental Problems:		
AXIS V Current GAF: **Highest in Past Year:**		

X. INTERPRETIVE SUMMARY (Include progress toward goals and service recommendations)

XI. ANNUAL CLIENT NOTIFICATION REQUIREMENTS (please check and date)

Local mental health programs shall inform client receiving mental health services verbally or in writing that:

☐ Acceptance and participation in the mental health system is voluntary and shall not be considered a prerequisite for access to other community services.

☐ Clients retain the right to access other Medi-Cal or Short Doyle/Medi-Cal reimbursable services and have the right to request a change of provider, staff person, therapist, and/or case manager.

☐ Language/Interpretation services availability reviewed and offered on: _____

☐ Beneficiary Handbook was offered/given to client on: _____

☐ Grievance/Appeal process reviewed and brochure offered on: _____

Completed by: _____ _____ _____

Signature/Licensure/Title Printed Name Date Total Time

Co-signature: _____ _____

(If required) Signature/Licensure Printed Name Date

COMMUNITY FUNCTIONING EVALUATION

WHEN: Within one month of the first planned service (Crisis Services are not considered planned services). A new Community Functioning Evaluation (CFE) shall be prepared annually.

ON WHOM: All clients receiving services beyond one month.

COMPLETED BY: Any service delivery staff participating in the evaluation.

MODE OF COMPLETION: Legibly handwritten, typed or word processed on form HHSA:MHS-976.

REQUIRED ELEMENTS: Evaluation of current level of functioning and level of support and impairment in four target areas: living arrangements, daily activities, social relationships, and health. Cultural issues should be considered in all areas.

BILLING: Write a progress note stating date started and completed. Include findings and necessary changes to Client Plan (if any). Note in the column the number of minutes for CFE preparation, interview and documentation. Include time with primary service rendered.

1. Living Arrangements — Wants/Needs

Current

- ☐ Acute Inpatient
- ☐ Homeless
- ☐ House/Apartment
- ☐ Residential Care Facility
- ☐ Shelter
- ☐ Single Room
- ☐ Transitional/Semi-Independent
- ☐ Other_____

Months at current living situation: _____

Housing at risk ☐ Yes ☐ No

Comments:_____

_____

2. Social Relationships — How Often — Wants/Needs Assistance

Participates in/with:

- ☐ Family
- ☐ Friends
- ☐ Recovery Groups
- ☐ Recreation Alone
- ☐ Recreation with others
- ☐ Social Support Groups
- ☐ None
- ☐ Other:_____

Comments:_____

_____

3. Daily Activities — Wants/Needs Assistance

Satisfactory

- ☐ Budgeting/Money Management
- ☐ Eating
- ☐ Grooming/Hygiene
- ☐ Housekeeping
- ☐ Keeps Appointments
- ☐ Laundry
- ☐ Shopping
- ☐ Uses Phone
- ☐ Uses Public Transportation

Other:_____

Comments:_____

_____

Current Activities — Wants/Needs Assistance

Day Program:_____

Employment:_____

School/Training:_____

Volunteer work:_____

Comments:_____

_____

4. HEALTH (In last year): — Wants/Needs

1. Takes medication as prescribed ☐ Yes ☐ No
2. Medical Hospitalizations ☐ Yes ☐ No
3. Psychiatric Hospitalizations ☐ Yes ☐ No
4. Substance Abuse Treatment ☐ Yes ☐ No
5. Substance Abuse/Dependence_____
6. Length of time clean/sober_____
7. Last _____

Eye Exam _____ ☐

Dental Exam _____ ☐

Physical Exam _____ ☐

Psychiatric Visit _____ ☐

Current Issues:_____ ☐

_____

5. FINANCIAL STATUS/EMPLOYMENT (Optional) — Wants/Needs

Has: — Amount

- ☐ AFDC _____ ☐
- ☐ Employment _____ ☐
- ☐ General Relief _____ ☐
- ☐ Medi-Cal _____ ☐
- ☐ Medicare _____ ☐
- ☐ Retirement _____ ☐
- ☐ SSA _____ ☐
- ☐ SSI _____ ☐
- ☐ Unemployment _____ ☐
- ☐ None

Comments_____

6. LEGAL/CASE MANAGEMENT STATUS (Optional) — Wants/Needs

Has:

- ☐ Case Manager:_____ ☐
- ☐ Conservator:_____ ☐
  - ☐ LPS:_____ ☐
  - ☐ Probate:_____ ☐
  - ☐ Temporary:_____ ☐
- ☐ Parole Officer:_____ ☐
- ☐ Payee:_____ ☐

Convictions:_____

_____

Legal Issues:_____

_____

_____

7. BEHAVIORAL RISK ISSUES (Optional):

History of:

- ☐ AWOL
- ☐ Careless Smoking
- ☐ Assault
- ☐ Suicide Attempts
- ☐ Fire Setting
- ☐ Inappropriate Sexual Behavior
- ☐ Incontinence
- ☐ Non-ambulation
- ☐ Property damage

Cultural Concerns:_____

_____

Evaluator's Signature | Title | Date

PLANS

CLIENT PLAN

WHEN: Within one month of the first planned service; (crisis services are not considered planned services), or within one month for an added service or when there is a significant change in the client's planned care.

UPDATES: The Client Plan must be updated every six months or more often when clinically indicated. To update the client plan, review the plan and make necessary changes based on the client's condition and the plan of care. The client's signature is required for both the initial plan and all updates. Medication Only Clients need to be updated annually or more often if clinically indicated.

ON WHOM: All clients receiving services for more than one month.

COMPLETED BY: Staff delivering services within scope of practice. Must be signed by Physician; licensed/waivered Psychologist, licensed/registered/waivered social worker, licensed/registered/waivered Marriage Family Therapist, or a Registered Nurse.

MODE OF COMPLETION: Legibly handwritten, typed, or word processed on form HHSA:MHS-975.

REQUIRED ELEMENTS: Client's overall goal for treatment, barriers to goal, client's strengths, identified objectives, interventions, person(s) responsible for interventions, date objective completed, client signature.

BILLING: Write a progress note stating date, total time, face to face time, and reference to the client plan activity.

Note in the column the procedure code. Refer to billing record for appropriate procedure code.

Care Coordinator: _____ Annual Review Date_____

Goal: _____

_____

Barriers, behaviors, symptoms or obstacles that might jeopardize achieving of goal: _____

_____

Client strengths and abilities to apply toward goal: _____

_____

Objectives (measurable, achievable, time limited, include date:)	Interventions (include frequency, duration)	Person (s) responsible	Date objective completed

I participated in the development of this plan and received a copy:

Client signature: _____ Staff signature: _____ Co-signature (if required): _____

Date: _____ Date: _____ Date: _____

Client Plan Update

Client signature:_____ Staff signature: _____ Co-signature (if required): _____

Date: _____ Date: _____ Date: _____

CRISIS/RECOVERY PLAN

WHEN: Complete when there is risk or concern that crisis intervention may be needed.

ON WHOM: As clinically indicated.

COMPLETED BY: Staff delivering services within scope of practice, preferably the client's care coordinator.

MODE OF COMPLETION: Handwritten, typed, or word-processed on form HHSA:MHS-116.

REQUIRED ELEMENTS: Early Warning signs, what client will do if signs appear, resources available to client, and what ACCESS should do.

Early warning signs that I need help are:

When I have any of these early warning signs I will:

The resources I have available to me are! (Include telephone numbers)

If I go into crisis I would like ACCESS to:

Client Signature Date:	Staff Signature: Date:

NOTES

INDIVIDUAL PROGRESS NOTE

WHEN:

This form is required to document services provided that are billed to the following CPT codes: 90804, 90806, 90808, 90810, 90812 or 90814.
Only one service contact is recorded per form.
Note: This form may also be used to document other types of mental health services at the discretion of the service provider.

ON WHOM:

All clients receiving services that will be billed to CPT codes 90804, 90806, 90808, 90810, 90812 or 90814.

COMPLETED BY:

Staff delivering services within scope of practice.

MODE OF COMPLETION:

Legibly handwritten, typed or word processed on form HHSA:MHS-925.

REQUIRED ELEMENTS:

The progress note must include the following information:

- ✓ Date of service
- ✓ CPT/HCPCS code
- ✓ DSM-IV-TR/ICD-9 diagnosis code(s)
- ✓ Location of service
- ✓ Provider staff ID
- ✓ Face to face time (direct time)
- ✓ Total time
- ✓ Signature, title, credential
- ✓ Date of documentation
- ✓ Printed name or use of stamp

Refer to Documentation Requirements Grid for specific required elements that pertain to the CPT code billing to. Documentation to address the relevant following parameters if indicated:

- What happened during therapy in relation to the initial findings?
- What therapeutic interventions were used?
- What was client's response to the interventions used?
- What progress is made toward the treatment goal?
- Are any new obstacles to treatment discovered?
- Are there any revisions to diagnosis or therapeutic plan?
- Have any referrals been made for other therapy?
- Have any consultations been made to obtain additional diagnosis or treatment recommendations?

All entries into a client record must contain a signature and include the professional license and/or degree, and/or job title of the service provider. In addition, to ensure legibility, the entry must also contain either the service provider's printed name or stamp, either of which also bears the professional license and/or degree, and/or job title. All entries into a client record must also contain both the date the service was provided and the date of documentation.

BILLING:

Note in the designated box on the form the procedure code and the total number of minutes.

To calculate total number of minutes include preparation time, interview time, and documentation time. Also note in the designated box on the form the number of minutes spent solely as face-to-face time (direct time).

For example: Total: 120 Minutes
Direct: 60 Minutes

Date of Service: MM / DD / YY	CPT/HCPCS Code:	Location of Service: 1=Office, 2=Field, 3=Phone, 4=Home, 5=School, 6=Satellite, 7=Crisis Field, 8=Jail, 9=Inpatient.
Provider Staff ID:	Total Time: HR: MIN:	F/F Time: HR: MIN:
Focus of session.		
DSM-IV-TR Diagnosis Code(s):	ICD-9 Billing Code(s):	

Current Condition (include complaints, symptoms, appearance, cognitive capacity, changes from previous visits, potential for harm, precipitators, strengths):

Therapeutic Intervention:

Response to Treatment:

Progress Toward Measurable Goals/Objectives:

Plan of Care (include indicated client plan changes, next steps, referrals given):

Other Information:

Signature/Title/Credential | Date | Printed Name

Co-Signature/Title/Credential | Date | Printed Name

GROUP PROGRESS NOTE

WHEN:

This form is required to document services provided that are billed to the following CPT codes: 90853 or 90857.
Only one service contact is recorded per form.
Note: This form may also be used to document other group mental health services at the discretion of the service provider.

ON WHOM:

All clients receiving services that will be billed to CPT codes 90853, or 90857.

COMPLETED BY:

Staff delivering services within scope of practice.
Note: When more than one staff member provides services, one staff member may write the progress note for all staff; but the role/function of each staff member participating must be documented.

MODE OF COMPLETION:

Legibly handwritten, typed or word processed on form HHSA:MHS-924.

REQUIRED ELEMENTS:

The progress note must include the following information:

- ✓ Date of service
- ✓ CPT/HCPCS code
- ✓ DSM-IV-TR/ICD-9 diagnosis code(s)
- ✓ Location of service
- ✓ Group formula
- ✓ Provider staff ID
- ✓ Provider co-staff ID
- ✓ Face to face time (direct time)
- ✓ Total time
- ✓ Signature, title, credential
- ✓ Date of documentation
- ✓ Printed name or use of stamp

Refer to Documentation Requirements Grid for specific required elements that pertain to the CPT code billing to. Documentation to address the relevant following parameters if indicated:

- What happened during therapy in relation to the initial findings?
- What therapeutic interventions were used?
- What was client's response to the interventions used?
- What progress is made toward the treatment goal?
- Are any new obstacles to treatment discovered?
- Are there any revisions to diagnosis or therapeutic plan?
- Have any referrals been made for other therapy?
- Have any consultations been made to obtain additional diagnosis or treatment recommendations?

All entries into a client record must contain a signature and include the professional license and/or degree, and/or job title of the service provider. In addition, to ensure legibility, the entry must also contain either the service provider's printed name or stamp, either of which also bears the professional license and/or degree, and/or job title. All entries into a client record must also contain both the date the service was provided and the date of documentation.

BILLING:

Note in the designated box on the form the procedure code and the total number of minutes.

To calculate total number of minutes include preparation time, interview time, and documentation time. Also note in the designated box on the form the number of minutes spent solely as face-to-face time (direct time).
For example: Total: 120 Minutes
Direct: 60 Minutes

Date of Service: MM/DD/YY	CPT/HCPCS Code:	Location: *	Group Formula # Minutes X ___ #Staff / ___ # Clients = ___
Provider Staff ID:	Provider Co-Staff ID:	Face to Face Time: HR: MIN:	Total Time: HR: MIN:

Focus of Treatment:
DSM-IV-TR Diagnosis Code(s): ICD- 9 Billing Code (s):

Affect/Mood: ☐ Appropriate ☐ Flat ☐ Blunted ☐ Elevated ☐ Anxious ☐ Irritable ☐ Depressed ☐ Restricted ☐ Labile ☐ Incongruent ☐ Other: _____

Appearance: ☐ Clean ☐ Disheveled ☐ Malodorous ☐ Well-Nourished ☐ Malnourished ☐ Other: ____

Orientation: ✓=Yes	☐ Person	☐ Place	☐ Time ☐ Day ☐ Month ☐ Year	☐ Current Situation	☐ All Normal

Precipitators/Recent Stressors: ☐ No ☐ Yes Describe:

Safety Issues: ☐ No ☐ Yes Describe:

Review of Group (include client's complaints/symptoms/focus of group/interventions):

Progress Towards Measurable Goals/Objectives:

Changes to Plan of Care Indicated? ☐ **Yes** ☐ **No**
Plan:

Signature/Title/Credential	Date	Printed Name
Co-Signature/Title/Credential	Date	Printed Name

* 1-Office, 2=Field, 3=Phone, 4=Home, 5=School, 6=Satellite, 7=Crisis Field, 8=Jail, 9=Inpatient

PROGRESS NOTE – OTHER SERVICES

WHEN: As needed to document client care at every service contact where a progress note entry is required. Multiple service contacts may be documented on this form.

ON WHOM: All clients receiving services.

COMPLETED BY: Staff delivering services within scope of practice.
Note: When more than one staff member provides services, one staff member may write the progress note for all staff; but the role/function of each staff member participating must be documented.

MODE OF COMPLETION: Legibly handwritten, typed or word processed on form HHSA:MHS-926.

REQUIRED ELEMENTS: For each separate chart entry, the progress note must include the following information:

- ✓ Date of service
- ✓ CPT/HCPCS code
- ✓ DSM-IV-TR/ICD-9 diagnosis code(s)
- ✓ Location of service
- ✓ Face to face time (direct time)
- ✓ Total time
- ✓ Signature, title, credential
- ✓ Date of documentation
- ✓ Printed name or use of stamp

Refer to Documentation Requirements Grid for specific required elements that pertain to the CPT code billing to. Documentation to address the relevant following parameters if indicated:

- What happened during therapy in relation to the initial findings?
- What therapeutic interventions were used?
- What was client's response to the interventions used?
- What progress is made toward the treatment goal?
- Are any new obstacles to treatment discovered?
- Are there any revisions to diagnosis or therapeutic plan?
- Have any referrals been made for other therapy?
- Have any consultations been made to obtain additional diagnosis or treatment recommendations?

All entries into a client record must contain a signature and include the professional license and/or degree, and/or job title of the service provider. In addition, to ensure legibility, the entry must also contain either the service provider's printed name or stamp, either of which also bears the professional license and/or degree, and/or job title. All entries into a client record must also contain both the date the service was provided and the date of documentation.

BILLING: Note on the form the procedure code and the total number of minutes. To calculate total number of minutes include preparation time, interview time, and documentation time. Also note on the form the number of minutes spent solely as face-to-face time (direct time).
For example: Total: 120 Minutes
Direct: 60 Minutes

FOR EACH CHART ENTRY, PLEASE INCLUDE THE FOLLOWING:

Date of Service: MM / DD / YY		CPT/HCPCS Code	DSM-IV-TR /ICD-9 Diagnosis Code(s)	Location of Service: 1=Office 2=Field 3=Phone 4=Home 5=School 6=Satellite 7=Crisis Field 8=Jail 9=Inpatient	
Face to face time	Total time in minutes	Signature/Title/Credential		Date	Printed Name

County of San Diego
Health and Human Services Agency
Mental Health Services

PROGRESS NOTE – OTHER SERVICES
HHSA:MHS-926 (01-14-2004)

Client: ______________________

MR/InSyst #: ______________________

RU/Program: ______________________

Medication Profile
(Contract Clinic Only)

WHEN:	Alternative method for documenting medications prescribed, dispensed, administered or discontinued.
ON WHOM:	All clients for whom medication is prescribed.
COMPLETED BY:	MD/DO
MODE OF COMPLETION:	Legibly handwritten, typed or word processed on form HHSA:MHS-913. Must write accompanying progress note when using HHSA:MHS-913.
REQUIRED ELEMENTS:	Date of service, medication and the name of the prescribing physician. Discontinued information.

Allergies:_____

Physical Problems:_____

Diagnosis:_____

Date	Medication, dose amount and frequency	Rx	Dispensed	Refills	Discont.	Prescribing MD/ Service Provider

Medication List
(County Clinic Only)

WHEN:	Alternative method for documenting medications administered or discontinued.
ON WHOM:	All clients for whom medication is prescribed.
COMPLETED BY:	MD/DO
MODE OF COMPLETION:	Legibly handwritten, typed or word processed on form HHSA:MHS-997. Must write accompanying progress note when using HHSA:MHS-997.
REQUIRED ELEMENTS:	Date of service, medication and the name of the prescribing physician. Discontinued information.

Allergies:_____

Date	Medication	Discontinued Date/Initial	PHYSICIAN

MEDICATION MANAGEMENT
(Non-SAN D/MAP)

WHEN: Alternative method for documenting medications prescribed, dispensed, administered, or discontinued.

ON WHOM: All clients for whom medication is prescribed.

COMPLETED BY: MD/DO.

MODE OF COMPLETION: Legibly handwritten, typed or word processed on form HHSA:MHS-928.

REQUIRED ELEMENTS: Date of service, medication, dose, frequency, route, site of administration, how dispensed, the name of the prescribing physician, number of refills, lab tests/other follow-up, program phone number, client address, CA license number and DEA number.

NOTE: Can be used instead of Medication Profile form.

BILLING: Note in the designated box on the form the procedure code and the total number of minutes. To calculate the total number of minutes include preparation time, interview time and documentation time. Also note in the designated box on the form the number of minutes spent solely as face-to-face time (direct time).

For example: Total: 120 Minutes
Direct: 60 Minutes

Date of Service: MM / DD / YY	CPT/HCPCS Code:	Location of Service: 1=Office, 2=Field, 3=Phone, 4=Home, 5=School, 6=Satellite, 7=Crisis Field, 8=Jail, 9=Inpatient.
Provider Staff ID:	Total Time: HR: MIN:	F/F Time: HR: MIN:
Focus of today's treatment DSM-IV-TR Diagnosis Code(s): _____	ICD-9-CM Billing Code(s): _____	

Medications:

Target Symptoms

Effect of Medication/Interventions/Level of functioning/ Medication Education

NO ☐ YES ☐ Explain Intervention:

SIDE/ADVERSE EFFECTS: } _____

Compliance: ☐ Yes ☐ No Date/Time of next appointment: _____

Lab Tests/Other Follow-up Recommended: _____

Injection Ordered: _____

M.S.E. _____

Any medication change? _____ If yes, include rationale for change: _____

PLAN:

Rx: PRESCRIPTION Generic Equivalent Permitted

Drug	Strength	Quantity	Refill	Directions

Medi-Cal ☐ Yes TAR done? _____

☐ No Signed Consent? _____

_____ _____ M.D./D.O.

Date Prescriber's Signature

_____

CA License No.

_____

Prescriber's Name (Print)

_____

DEA Number

Client: _____

MR/InSyst #: _____ **Date of Birth:** _____

Client Address: _____

Program: _____

Medication/Progress Note
(SAN D/MAP Programs)

WHEN:

This form is required to document services provided that are billed to the following CPT codes: H2010, 90862, M0064, 99078. This service includes evaluation of the need for medications, medication administration, evaluation of compliance, side effects and medication education.

COMPLETED BY:

A person prescribing, administering or dispensing medication who is operating within his/her scope of practice; a Nurse when documenting that an order has been followed.

ON WHOM:

All clients receiving services that will be billed to CPT Codes: H2010, 90862, M0064, 99078.

MODE OF COMPLETION:

Legibly handwritten, typed or word processed on form HHSA:MHS-125.

REQUIRED ELEMENTS:

The progress note must include the following information:

- Date of service
- CPT/HCPCS code
- DSM-IV-TR/ICD-9 diagnosis code(s)
- Location of service
- Provider staff ID
- Face to face time (direct time)
- Total time
- Signature, title, credential
- Date of documentation
- Printed name or use of signature stamp
- Medication prescribed
- Client education about the intended effect of the medication
- Description of the client's response to medication (in terms of decreased symptoms and/or increased–functioning), side effects and compliance (when there is a change), the plan for future services and the clinician's signature with title

BILLING:

Refer to Documentation Requirements Grid for specific required elements that pertain to the CPT code billing to. Documentation to address the relevant following parameters, if indicated:

- What happened during therapy in relation to the initial findings?
- What therapeutic interventions were used?
- What was client's response to the interventions used?
- What progress is made toward treatment goal?
- Are any new obstacles to treatment discovered?

- Are there any revisions to diagnosis or therapeutic plan?
- Have any referrals been made for other therapy?
- Have any consultations been made to obtain additional diagnosis or treatment recommendations?

All entries into a client record must contain a signature and include the professional license and/or degree, and/or job title of the service provider. In addition, to ensure legibility, the entry must also contain either the service provider's printed name or signature stamp, either of which bears the professional license or degree, and/or job title. All entries into a client record must also contain both the date the service was provided and the date of documentation.

If biopsychosocial treatment is indicated, document if a referral is made to a medical physician; its establishment or an attempt to establish it should be noted. This relationship should address possible physiological causes for impairments and the possible need for psychoactive medication. Include when appropriate, the evaluation and treatment of clients medical conditions. Axis III should be documented, when the current general medical conditions are potentially relevant to the understanding or management of the individuals' mental disorder.

Nursing: Nurses use the Medication/Progress Note form for all client contacts concerning medication and labs.
Examples: Complete the "Medication/Progress Note" when:
- doing labs
- urine drug screen
- reordering medications
- giving pre-packs between MD/DO visits

Complete this form when the nurse is the sole provider of services on a given day, regardless of the task, since the nurse will be responsible for an assessment of the client in addition to the task at hand. When a nurse simply carries out an order for a blood draw or injection, the order should always be checked, initialed, dated, where the order is written on the completed medication/progress note filled out by the MD/DO.

Note in the tables the procedures code and the total number of minutes. To calculate total number of minutes include preparation time, interview time and documentation time spent solely as face-to-face time (direct time).

For example:	Total:	120 minutes
	Direct:	60 minutes

Note: It is possible that multiple persons/disciplines may complete and bill different portions of this form. Each time a service is rendered, the appropriate time allotment and CPT/HCPCS codes are to be documented.

Date of Service: MM / DD / YY	Provider Staff ID:	Location of Service: 1-Office, 2=Field, 3=Phone, 4=Home, 5=School, 6=Satellite, 7=Crisis Field, 8=Jail, 9=Inpatient.
Focus of today's treatment DSM-IV-TR Diagnosis Code(s):	ICD-9-CM Billing Code(s):	

A. Vital Signs: (if needed) Blood Pressure_____ Pulse_____ Temp_____ Weight_____ Girth_____ Height_____ BMI _____

Comments: _____

Has client taken medication as prescribed? ☐Yes ☐No_____

Any changes of other medications since last visit? (include over the counter) ☐ NO_____

Substance use? ☐Yes ☐No If yes, specify substance:_____

_____

Signature /Title | Printed Name | Date | Face to Face Time/Total Time | CPT/HCPCS Code

B. Algorithm Rating Scales

Patient Global Self Report (0 - 10) 0=no symptoms, 5=moderate, 10=extreme

Symptom Severity: _____ Side Effects: _____

Participation in Road Map to Recovery groups ☐Yes ☐No Number of Sessions Attended: _____

Clinical Rating Scale: QIDS-SR_____QIDS-C _____

Positive Symptoms (PSRS) _____ Negative Symptoms (BNSA)_____ BDSS _____

_____

Signature /Title | Printed Name | Date | Face to Face Time/Total Time | CPT/HCPCS Code

CURRENT ALGO: _____SCHIZ _____MDDNP _____MDDP _____BPD

STAGE: _____; WEEKS IN THIS STAGE: _____;

C. CLINICIAN INFORMATION

Use for all clinicians' rating below: (0-10; 0=No Symptoms; 5=Medium and 10=Extreme)

Core Symptoms: _____Manic _____Depression _____Psychosis Positive Symptoms _____Negative Symptoms

Other Symptoms: _____Irritability _____Mood Lability _____Agitated _____Anxiety _____Level of Interest

_____Appetite _____Energy Level _____Insomnia _____Impulse Control _____Interpersonal Relationships

_____Sexual Functioning Side Effects_____

CURRENT POTENTIAL FOR HARM: Homicidal? ☐Yes ☐No Suicidal? ☐Yes ☐No

Comments:_____

_____

SYMPTOMATIC RESPONSE TO MEDICATION: ☐Full Remission ☐Partial ☐No Change ☐Worsening

If medication type or dose is being changed at this visit, indicate reasons for change.

** ☐Critical Decision Points Indicates Change ☐Diagnosis Change ☐Insufficient Improvements ☐Client Preference

☐Side Effects Intolerable ☐Symptoms Worsening ☐Other (specify)_____

Comments:

_____

_____

_____

_____

County of San Diego
Health and Human Services Agency
Mental Health Services

MEDICATION/PROGRESS NOTE

Client

Name:_____

MR/Client ID #: _____

Program

Program: _____ **Phone #**_____

Address:_____

D. **MENTAL STATUS EXAM:**

Level of Consciousness:	☐Alert	☐Lethargic	☐Stuporous				
Orientation:	☐Person	☐Place	Time ☐Day ☐Month ☐Year	☐Current Situation			☐ All Normal
Appearance:	☐Clean	☐Disheveled	☐ Malodorous	☐Well-Nourished	☐Malnourished	☐Obesity	☐ Reddened Eyes
Speech:	☐Normal	☐Slurred	☐Loud		☐Pressured	☐Slow	☐Mute
Thought Process:	☐Coherent	☐Tangential	☐Circumstantial		☐Incoherent		☐Loose Association
Thought Content	☐Auditory Hallucinations	☐Visual Hallucinations	☐Delusions		☐Ideas of Reference		☐Paranoia
Behavior:	☐Cooperative	☐Evasive	☐Uncooperative		☐Threatening	☐Agitated	☐Combative
Affect:	☐Appropriate	☐Blunted	☐Flat		☐Restricted	☐Labile	☐Other
Intellect:	☐Normal	☐Below Normal	☐Paucity of Knowledge	☐Vocabulary Poor	☐Poor Abstraction		☐ Uncooperative
Mood:	☐Euthymic	☐Elevated	☐Euphoric	☐Depressed	☐Anxious		☐Irritable
Memory:	☐Normal	☐ Poor Recent	☐ Poor Remote	☐ Inability to Concentrate	☐ Confabulation		☐Amnesia
Insight	☐Normal	☐Adequate	☐Marginal	☐Poor			
Judgment:	☐ Normal	☐Poor	☐Unrealistic		☐Unmotivated	☐Uncertain	
Motor:	☐ Normal	☐Decreased	☐Agitated	☐Tremors	☐Tics	☐Repetitive Motions	☐Psycho-Motor Retardation
Global AIMS:	0	1	2	3	4		

Note: A narrative mental status exam may be done on a progress note, in lieu of above.

DSM IV-TR DIAGNOSIS: _____.___; _____.___; _____.___; _____.___; GAF: _____

E. **Psychotherapeutic interventions: Return visit, discharge planning.**

_____

_____

_____

_____

_____

F. **Plan/Order/SNP: Psychotherapeutic Interventions: Return visit, discharge planning. Medication Levels. Lab Work.**

_____

_____

_____

_____

Signature /Title Printed Name Date Face to Face Time/Total Time CPT/HCPCS Code

Comments: _____

_____

_____

_____

_____

_____

Signature /Title Printed Name Date Face to Face Time/Total Time CPT/HCPCS Code

MEDICATION PRESCRIPTION
(San D/Map Programs)

WHEN: At time medication is ordered.

ON WHOM: All clients for which an order is written.

COMPLETED BY: Individual prescribing medication.

MODE OF COMPLETION: Legibly handwritten, typed or word processed on form HHSA:MHS-994.

REQUIRED ELEMENTS: All items.

BILLING: Included as part of medication visit and billed through Medication Progress Note.

Client identified self according to Policy and Procedure 05-01-25: ☐Yes ☐ No ☐ N/A

*S=Meds targeted at core symptom. OS=Meds targeted at other symptoms. SE=Meds for side effects of S or OS.
SNP=Standardized Nursing Procedure.

Medication Name	Strength	Frequency	Quantity	Refill	Indication (check all that apply)*	Change from previous visit?	New/ Continuing/ Discontinue
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C
					☐S ☐OS ☐SE	☐Yes ☐No	☐New ☐Cont. ☐D/C

Generic Equivalent permitted unless otherwise noted.

☐ County Pharmacy

Pharmacy Name:______________________________ Pharmacy Phone Number: (___)____________

☐ Mail Out ☐ Fax Pickup: ☐ Pharmacy ☐ Clinic **Medi-Cal:** ☐Yes ☐No

______ Date ______________ Signature MD/DO or RN under SNP ______________ CA License No. ______________ CPT/HCPCS Code

______________ Printed Name ______________ DEA Numbe

County of San Diego
Health and Human Services Agency
Mental Health Services

MEDICATION PRESCRIPTION

Client

Client:______________________________

MR/Client ID #: ______________ **DOB:** ______________

Address:______________________________

____

Program

Program: ______________ **Phone #**______________

Address:______________________________

HHSA:MHS-994 (05/25/2004) NCR

GAF UPDATE FORM

WHEN:

- Annual Update
- Whenever a Clinician determines an update is indicated

ON WHOM:

All Clients

COMPLETED BY:

- Physician
- Nurse
- Licensed or Waivered Clinician
- Case Manager
- Care Coordinator

MODE OF COMPLETION:

Clinician shall determine appropriate GAF upon face-to-face assessment of client.
Determination of GAF shall be

- Documented in Progress Note
- Recorded on GAF update form as instructed
- Entered into InSyst.

REQUIRED ELEMENTS:

- Circled section(s) of GAF description(s) that most closely match client's current GAF
- Admission GAF
- Annual Review Date
- GAF Score Today
- Today's Date
- Staff Signature/Title completing GAF form
- Name of Client
- Medical Record number of client
- Program

GLOBAL ASSESSMENT OF FUNCTIONING (GAF) UPDATE

Start at the bottom. ***Circle the appropriate description*** of the client's psychological functioning, social functioning, and occupational functioning on the continuum below. Do not include impairments in functioning due to physical or environmental limitations; acute and chronic physical illness. Do not attempt to adjust or compensate rating for the presence or absence of medications. Refer to the DSM IV TR as needed. **Appropriate documentation in the chart must support this update. The lowest scored indicator determines the client's GAF score.**

If the score is over 70 please consult your supervisor.

SCORE	PSYCHOLOGICAL FUNCTIONING	SOCIAL FUNCTIONING	OCCUPATIONAL FUNCTIONING
61-70	Some mild symptoms (e.g., depressed mood and mild insomnia)	Some difficulty in social functioning but generally functioning pretty well has some meaningful interpersonal relationships.	Some difficulty in occupational or school functioning (e.g., occasional truancy or theft within the household)
51-60	Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks)	Moderate difficulty in social functioning (e.g., few friends, conflicts with peers)	Moderate difficulty in occupational or school functioning (e.g., conflicts with peers or co-workers)
41-50	Serious symptoms (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting)	Any serious impairment in social functioning (e.g., no friends)	Any serious impairment in occupational or school functioning (e.g., unable to keep a job)
31-40	Some impairment in reality testing or communication (e.g.. speech is at times illogical, obscure or irrelevant)	Major impairments in several areas, such as, family relations, judgement, thinking, or mood (e.g. depressed man avoids friends, neglects family)	Major impairments in several areas, such as work or school (e.g. depressed man is unable to work)
21-30	Behavior is considerably influenced by delusions or hallucinations	Serious impairment in communication or judgement (e.g. sometimes incoherent, acts grossly inappropriate, suicidal preoccupation)	Inability to function in almost all areas (e.g., stays in bed all day, no job, home or friends)
11-20	Some danger of hurting self or others (e.g., suicide attempts without a clear expectation of death: frequently violent: manic excitement)	Gross impairment in communication (e.g., largely incoherent or mute)	Occasionally fails to maintain minimal personal hygiene (e.g., smears feces)
1-10	Serious suicidal act with clear expectation of death	Persistent inability to maintain minimum personal hygiene	Persistent danger of severely hurting self or others (e.g., recurrent violence)
0	Inadequate Information		

Admission GAF: _____ Annual Review Date: _____

GAF Score Today: _____ **Today's Date:** _____

Staff Signature/Title: _____

County of San Diego
Health and Human Services Agency
Mental Health Service

GLOBAL ASSESSMENT OF FUNCTIONING UPDATE FORM

Client: _____

MR/Client ID #: _____

Program: _____

MEDICAL

INFORMED CONSENT FOR THE USE OF PSYCHOTROPIC MEDICATION

WHEN: Whenever psychotropic medication is prescribed.

ON WHOM: All clients receiving psychotropic medication.

COMPLETED BY: M.D.

MODE OF COMPLETION: Legibly handwritten on HHSA:MHS-005 or HHSA:MHS-006 (Spanish Version)

REQUIRED ELEMENTS: State law defines informed consent as the voluntary consent of the client to take psychotropic medication after the physician has reviewed the following with him/her:

- Explanation of the nature of the mental problem and why psychotropic medication is being recommended.
- The general type (antipsychotic, antidepressant, etc.) of medication being prescribed and the medication's specific name.
- The dose, frequency and administration route of the medication being prescribed.
- What situations, if any, warrant taking additional medications.
- How long it is expected that the client will be taking the medication.
- Whether there are reasonable treatment alternatives.
- Documentation of "informed consent" to take psychotropic medication. A new form is to be completed:
  - When a new or different type of medication is prescribed.
  - When the client resumes taking medication following a documented withdrawal of consent.

INFORMED CONSENT FOR THE USE OF PSYCHOTROPIC MEDICATION

Client Information and Consent (Please read this form carefully and completely)

- You have the right to be informed; be given information about your care and to ask questions.
- You have the right to accept or reject all or any part of your care plan.
- You have the right to revoke consent verbally or in writing to any member of the treating staff for any reason at any time.
- You have the right to language/interpreting services. Services Requested: ☐ YES ☐ NO
- You have the right to a copy of this Consent: Copy Requested? ☐ YES ☐ NO

Emergency Treatment: In certain emergencies, medication may be given to you when it is impractical to obtain consent. However, once the emergency has passed, medication will continue with your informed consent. *(An emergency is a temporary, sudden marked change requiring action to preserve life or prevent serious bodily harm to client or others).*

Your Physician is prescribing the following psychotropic medication(s) for you:

Medication(s) Name	Medication Info. Sheet Given (check box) ☑
	☐ YES ☐ NO
	☐ YES ☐ NO
	☐ YES ☐ NO
	☐ YES ☐ NO
	☐ YES ☐ NO
	☐ YES ☐ NO

In order to be informed and give consent, your doctor will discuss the following information with you:

Verbal Information Discussed with Client

1. Nature and seriousness of your mental illness
2. Reason(s) for medication(s) including the likelihood of improving, or not improving with or without the medication(s)
3. Reasonable alternative treatments and why doctor is recommending this particular treatment
4. Type, range of frequency and amount (including PRN orders), method (oral or injection), duration of taking medication(s)
5. Probable side effects known to commonly occur, and any particular side effects likely to occur with you
6. Possible additional side effects which may occur when taking medication(s) beyond three months
7. If prescribed a ***conventional/typical or atypical antipsychotic medication***, information will be given to you about **tardive dyskinesia,** a possible side effect caused by ***typical/atypical antipsychotic medication***. It is characterized by involuntary movements of the face or mouth and/or hands and feet. These symptoms are potentially irreversible and may appear after medication has been discontinued.

Client's Consent:

Based upon the information I have read, discussed and/or reviewed with my doctor:
(check one of the following)

- ☐ I understand and give consent to the use of the psychotropic medication(s) on page one.
- ☐ I give verbal consent only; refuse to sign form.
- ☐ I do not approve/consent to the use of the psychotropic medication(s) listed below.

Please list: _____

_____

Signature of Client/Legal Rep./Guardian Date

Doctor's Statement:

I have reviewed, discussed and recommend the medication plan (page 1) for above client and:

- ☐ Client gives consent to take these medications.
- ☐ Client gives verbal consent, but unwilling or unable to sign.
- ☐ Emergency. Given medication without consent.
- ☐ Unable to understand risks and benefits, and therefore cannot consent.
- ☐ Other Comments: _____

_____

_____

Psychiatrist's Signature Date

_____

Printed Name

_____

Witness Signature (if applicable): Date

THÔNG TIN VỀ VIỆC ĐỒNG Ý DÙNG THUỐC CÓ ẢNH HƯỞNG TÂM THẦN

Tài liệu về thân chủ và Sự Đồng Ý (Consent).

Bạn có quyền được biết, được thông báo và được quyền hỏi cho rõ về việc chữa trị cuả bạn.

Bạn có quyền chấp nhận hay chối bỏ tất cả hay một phần trong chương trình chữa trị cho bạn.

Bạn có quyền rút lại sự đồng ý bằng lời nói hay viết đơn tới bất cứ nhân viên chữa trị bất cứ lúc nào và vì bất cứ lý do gì.

Bạn có quyền xin dịch vụ thông dịch. Bạn có cần không: ☐ CÓ ☐ KHÔNG

Bạn có quyền giữ một bản sao của tờ Đồng ý này: Bạn có muốn không? ☐ CÓ ☐ KHÔNG

Chữa Trị Khẩn Cấp: Trong một số trường hợp khẩn cấp , bạn được dùng thuốc dù không thể lấy bản đồng ý. Tuy nhiên, khi khẩn cấp đã qua, thuốc sẽ được cung cấp với sự đồng ý cuả bạn *(Khẩn cấp là một lúc cấp thời, sự việc xẩy ra đòi hỏi hành động phải làm để duy trì mạng sống và tránh thương tích cho bệnh nhân và cho các người khác).*

Bác sĩ cuả bạn đã kê các thuốc có tác dụng tâm thần sau nay cho bạn:

Tên Thuốc	Tên Thuốc

Để hiểu rõ và đồng ý,bác sĩ của bạn sẽ bàn về các dữ kiện sau nay với bạn:

Các điều đã thảo luận bằng lời nói với thân chủ

1. Bệnh trạng nặng nhẹ về tâm thần của bạn
2. Lý do dùng thuốc, kể cả cơ hội sẽ bớt bệnh, hay không bớt, cho dù có thuốc hay không.
3. Các cách chữ trị khác và lý do bác sĩ chọn cách chữa trị này
4. Loại, tính thường xuyên, số lượng (kể cả toa PRN), Phương thức (chích hoặc uống), thời gian dùng thuốc bao lâu .
5. Các phản ứng phụ thường xảy ra, và bất cứ các phản ứng phụ có thể xẩy ra cho bạn.
6. Các phản ứng phụ có thể xảy ra khi dùng thuốc lâu hơn ba tháng.
7. Nếu kê toa loại thuốc ***theo quy ước/thông thường hay không thông thường chống rối loạn tâm thần,*** dữ kiện sẽ cung cấp cho bạn về **tardive dyskinesia,** một phản ứng phụ có thể xẩy ra bởi ***thuốc chữa trị thông thường hay không thông thường*** . Phản ứng này gây ra việc tự nhiên rung bắp thịt mặt, miệng và/hoặc tay chân. Những triệu chứng này có thể không trở lại bình thường và có thể xẩy ra sau khi đã ngừng thuốc.

Sự Đồng Ý của Bệnh Nhân:

Sau khi đã đọc những thông tin trên, bàn thảo và coi lại với bác sĩ của tôi :
(chọn một trong những câu dưới đây)

- ☐ Tôi hiểu và đồng ý dùng các thuốc có ảnh hưởng tâm thần ở trang 1.
- ☐ Tôi đồng ý bằng lời nói mà thôi; từ chối ký tên vào mẫu.

Tôi không chấp thuận/đồng ý để dùng các thuốc thuốc có ảnh hưởng tâm thần sau đây:

Xin kể ra: _____

_____

Chữ kýcủa khách hàng/Đại diện pháp lý/Người giám hộ Ngày

Lời Ghi của Bác Sĩ:

Tôi đã coi lại, bàn thảo và đề nghị thuốc chữa trị (Trang 1) cho bệnh nhân nói trên và:

- ☐ Bệnh nhân đồng ý dùng các thuốc .
- ☐ Bệnh nhân đồng ý bằng lời nói; nhưng không muốn ký tên vào mẫu
- ☐ Khẩn cấp, Cho dùng thuốc không có sự đồng ý.
- ☐ Không hiểu sự nguy hiểm và phúc lợi của thuốc, do đó không thể đồng ý.
- ☐ Ghi chú thêm: _____

_____

_____

Chữ ký bác sĩ tâm thần: Ngày

_____

Viết tên

_____

Chữ ký nhân chứng (nếu có): Ngày

إتفاق إستعمال العلاج النفسي

معلومات العميل و قبوله بشروط الإتفاق (الرجاء مراجعة هذه الإستمارة بدقة و بشكل كامل)

- لديك حق الإطلاع على المعلومات المتعلقة بعلاجك و حق طرح أي أسئلة تتعلق بذلك.
- لديك الحق بقبول أو رفض أي جزء من خطة علاجك.
- لديك الحق بإلغاء هذا الإتفاق شفهياً أو تحريرياً و ذلك عن طريق إبلاغ أي من أعضاء الفريق المشرف على علاجك و ذلك لأي سبب كان و في أي وقت تختاره.
- لديك حق الحصول على خدمات الترجمة بلغتك الأم. هل ترغب بالحصول على خدمات الترجمة؟ ☐ نعم ☐ لا
- لديك الحق بالحصول على نسخة من هذا الإتفاق. هل ترغب بالحصول على نسخة من هذا الإتفاق؟ ☐ نعم ☐ لا

العلاج في الحالات الطارئة: في بعض الحالات الطارئة، قد يتم إعطائك دواءاً (عقاراً) معيناً عندما يكون من غير الممكن الحصول على موافقتك على ذلك. لكن بعد تجاوز الحالة الطارئة، سيستمر إستخدام الدواء (العقار) فقط بعد موافقتك على ذلك. *(الحالة الطارئة هي حالة مؤقتة، يصاحبها تغير مفاجئ يتطلب فعل ما لحماية إستمرارية الحياة أو منع حصول أذى خطير لجسد العميل أو الأخرين).*

يصف طبيبك الأدوية (العقاقير) التالية لك:

إسم الدواء (العقار)	بيانات الدواء (العقار). هل تم إعطاءك بيانات الدواء (العقار) (إختر المربع المناسب) ☑
	☐ نعم ☐ لا
	☐ نعم ☐ لا
	☐ نعم ☐ لا
	☐ نعم ☐ لا
	☐ نعم ☐ لا
	☐ نعم ☐ لا

من أجل أن يتم إطلاعك على المعلومات و الحصول على موافقتك، سيقوم طبيبك بمناقشة المعلومات الواردة أدناه معك:

المعلومات التي سيتم مناقشتها مع العميل شفهياً

1. طبيعة و خطورة مرضك النفسي
2. الأسباب التي تستدعي أخذك للدواء (العقار) و بضمنها إحتمالية تحسن حالتك أو عدم تحسنها عند أخذ أو عدم أخذ الدواء (العقار)
3. دواء (عقار) بديل منطقي و سبب إختيار الطبيب لهذا الدواء (العقار) بالذات
4. نوع و عدد مرات إستخدام و كمية (بضمنها الدواء الذي يؤخذ عند الحاجة فقط) و طرق (سواء كان عن طريق الفم أو الحقن) و الفترة التي يجب خلالها أخذ الدواء (العقار)
5. الأعراض الجانبية المحتمل حدوثها، و أي أعراض جانبية يمكن أن تتعرض لها
6. الأعراض الجانبية المحتمل حدوثها عند إستخدام الدواء (العقار) لأكثر من ثلاثة أشهر
7. إن تم وصف دواء (عقار) إعتيادي أو غير إعتيادي للذهان (الهذيان)، سيتم إطلاعك على بينات حالة Tardive Dyskinesia و هي عرض جانبي محتمل عند إستخدام الدواء (العقار) الإعتيادي أو الغير الإعتيادي للذهان. يمكن تشخيص أعراض هذه الحالة بالحركات اللاإرادية لعضلات الوجه و الفم و/أو اليدين و القدمين. عادة، ليس بالمستطاع التخلص من هذه الأعراض و قد تستمر بالحصول حتى بعد توقفك عن أخذ الدواء (العقار).

موافقة العميل

بناءاً على المعلومات التي قرأتها و/أو قمت بمناقشتها و/أو مراجعتها مع طبيبي:
(حدد خياراً واحداً من الخيارات التالية)

- ☐ إني أقر و أوافق على إستخدام الأدوية (العقاقير) الواردة في الصفحة رقم 1 من هذه الإستمارة.
- ☐ أمنح موافقتي الشفهية فقط، و أرفض توقيع هذه الإستمارة.
- ☐ لا أوافق على إستخدام الأدوية (العقاقير) المذكورة أدناه.

الرجاء ذكر أسماء الأدوية (العقاقير) _____

_____

توقيع العميل/الممثل القانوني/الوصي التأريخ

بيان الطبيب

لقد قمت بمراجعة و مناقشة و نصح العميل المذكور أعلاه بخطة العلاج الواردة في الصفحة رقم 1 من هذه الإستمارة و:

- ☐ وافق العميل على أخذ هذه الأدوية (العقاقير)
- ☐ وافق العميل شفهياً على أخذ هذه الأدوية (العقاقير)، إلا إنه غير راغب أو غير قادر على توقيع هذه الإستمارة.
- ☐ الحالة طارئة، و تم إعطاء العلاج للعميل دون موافقته.
- ☐ لم يكن العميل قادراً على تفهم المخاطر و الفوائد و لذلك لا يستطيع الموافقة.
- ☐ تعليقات أخرى: _____

_____

_____ _____

توقيع الطبيب النفسي التأريخ

_____

الإسم (يكتب بشكل واضح)

_____ _____

توقيع الشاهد (إن وجدت الحاجة إليه) التأريخ

Lab Reports Filed Here

MEDICAL HISTORY QUESTIONNAIRE

WHEN: Within two months after the first planned service.

UPDATES: When clinically appropriate, review at least annually.

ON WHOM: All clients receiving services beyond two months.

COMPLETED BY: The client or a support person.

MODE OF COMPLETION: Hand written on form HHSA:MHS-911 or 921 (Spanish Version).

REQUIRED ELEMENTS: All pertinent sections, both front and back.

BILLING: Write a progress note referencing the Medical History Questionnaire. *Note in the column the procedure code and the total number of minutes. Refer to billing record for appropriate procedure code. To calculate total numbers of minutes include preparation time, interview time, and documentation time.* ***Also*** *note in the column the number of minutes spent solely as face-to-face time (direct time).*

For Example: Total: 120 Minutes
Direct: 60 Minutes

Refer to billing record for appropriate procedure code.

Date of last visit to a physician: _____ Purpose of Visit: _____

Doctor's name: _____ Phone #: (___) _____

Address: _____

Name of current personal Physician: _____

Family History	Name:	Age:	If Deceased, Cause of Death	Age at Death	Has any blood relative ever had:	Encircle No or Yes	Who?
Father					Alcoholism	No Yes	
Mother					Drug Problems	No Yes	
Brother/s	1.				Depression	No Yes	
Or	2.				Mental Problems	No Yes	
Sister/s	3.				Psychiatric Treatment	No Yes	
	4.				Epilepsy	No Yes	
Spouse	5.				Neurological Disorder	No Yes	
Children	1.				Suicidal Attempts	No Yes	
	2.						
	3.						
	4.						
	5.						
Medical History	**Please place a check ✔ in front of any questions you would like to discuss in more detail with the Doctor.**						

Have you ever had:	Circle No or Yes
Rheumatic Fever	No Yes
Epilepsy	No Yes
Tuberculosis	No Yes
Nervousness	No Yes
Mental Problem	No Yes
Arthritis	No Yes
Bone or Joint Disease	No Yes
Meningitis	No Yes
Gonorrhea or Syphilis	No Yes
Jaundice	No Yes
Thyroid Disease	No Yes
Diabetes	No Yes
Cancer	No Yes
High Blood Pressure	No Yes
Heart Disease	No Yes
Asthma	No Yes
Stroke	No Yes

When was your last physical Examination? _____

What Medications are you allergic to? _____

Have you ever been hospitalized for any major illness? Specify: _____

_____

When and where you hospitalized: _____

Have you ever had an operation? Type and When: _____

Do you currently have any dental problems? _____

Have you had any complications from a childhood disease? _____

When was your last chest x-ray? _____

When was your last electrocardiogram? _____

What do you weigh now? _____

What was your weight one year ago? _____

What was your maximum weight and date? _____

Has Sleep been a problem? _____

Has sex been a problem? _____

Has there been a change in appetite? _____

What activities do you do for fun? _____

What time do you feel your best? _____

What physical complaints, if any do you have? _____

What medications do you take on a regular basis? _____

_____

Doctor's Notes: _____

_____

_____

Systems History Place a check ✓ in front of any questions that you would like to discuss in more detail with the Doctor.

Have you ever had any of the following problems

	Circle	No	Yes		Circle	No	Yes
Any eye disease injury, impaired sight		No	Yes	Night sweats		No	Yes
Any ear disease, injury, impaired hearing		No	Yes	Shortness of breath		No	Yes
Trouble with nose, sinuses, mouth or throat		No	Yes	Palpitations or fluttering heart		No	Yes
Head injuries		No	Yes	Swelling of hands, feet or ankles		No	Yes
Fainting spells		No	Yes	Back, arm or leg problem		No	Yes
Loss of Consciousness		No	Yes	Varicose veins		No	Yes
Convulsions		No	Yes	Kidney disease or stones		No	Yes
Paralysis		No	Yes	Bladder disease		No	Yes
Dizziness		No	Yes	Albumin, sugar, pus, blood in urine		No	Yes
Frequent or severe headaches		No	Yes	Difficulty in urinating		No	Yes
Depression or anxiety		No	Yes	Abnormal thirst		No	Yes
Difficulty concentrating		No	Yes	Stomach trouble or ulcer		No	Yes
Memory problems		No	Yes	Indigestion		No	Yes
Extreme tiredness or weakness		No	Yes	Appendicitis		No	Yes
Hallucinations		No	Yes	Liver or gallbladder disease		No	Yes
Enlarged glands		No	Yes	Colitis or other bowel disease		No	Yes
Enlarged thyroid or goiter		No	Yes	Hemorrhoids or rectal bleeding		No	Yes
Skin disease		No	Yes	Constipation or diarrhea		No	Yes
Chronic or frequent cough		No	Yes	Crying spells		No	Yes
Chest pain or angina pectoris		No	Yes	Suicidal thoughts		No	Yes
Coughing up blood		No	Yes	Loss of appetite		No	Yes

Habits

Do you smoke: ☐ Tobacco ☐ Cigarettes How many packs a day_____

Do you drink: ☐ Coffee ☐ Tea ☐ Cola Drinks How many cups/glasses a day_____

Do you take alcoholic beverages: ☐ Never ☐ Rarely ☐ Moderately ☐ Daily

Has alcohol use been a problem: ☐ Yes ☐ No Have you ever been treated for alcoholism: ☐ Yes ☐ No

Have you ever taken street drugs: ☐ Yes ☐ No Which drug/s:_____

During what Period:_____ How often:_____

When was the last time that you used any drug:_____

Have you ever been treated for a drug problem: ☐ Yes ☐ No When:_____

WOMEN ONLY: Menstrual History

Age at onset:_____ Cycle:_____ Days (from start to start) Date of last period:_____

Duration:_____ Days Regular: ☐ Yes ☐ No Pain or Cramps: ☐ Yes ☐ No

How many pregnancies: Miscarriages: Age of youngest living child:

Military History Not Applicable ☐

Branch_____ Rank at Discharge_____

When did you serve?_____ to_____

Type of discharge_____

Signature of Patient or Guardian_____
(Optional)

Date form Completed:_____

Doctor's Notes and Recommendations:

Physician's Signature & Date Reviewed.

Client: _____

MR/Client ID #: _____

Program: _____

ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

WHEN: Is not required if information is documented in the progress note.

ON WHOM: All clients receiving anti-psychotic medication. For clients under sixty (60) years of age due once a year and for clients over sixty (60) years of age every six (6) months.

COMPLETED BY: M.D., D.O., or Registered Nurse.

MODE OF COMPLETION: Legibly handwritten or typed on forms HHSA:MHS-914.

REQUIRED ELEMENTS: Facial and oral movements, extremity movements, trunk movements, global judgments, dental status, response to medication.

BILLING: Write a progress note stating "completed the AIMS of date." *Note in the column the procedure code and the total number of minutes. Refer to billing record for appropriate procedure code. To calculate total numbers of minutes include preparation time, interview time, and documentation time.* ***Also*** *note in the column the number of minutes spent solely as face-to-face time (direct time).*

For Example: Total: 120 Minutes
Direct: 60 Minutes

If done in conjunction with Meds visit, include time in visit time.

Complete Examination Procedure **MOVEMENT RATINGS**: Rate highest severity observed. Rate movements that occur upon activation one *less* than those observed spontaneously.	Code: 0 = None 1 = Minimal, may be extreme normal 2 = Mild 3 = Moderate 4 = Severe	
Muscles of Facial Expression e.g., movements of forehead, eyebrows, periorbital area, cheeks; include frowning, blinking, smiling, grimacing	Date: (Circle one) 0 1 2 3 4	Date: (Circle one) 0 1 2 3 4
Lips and Perioral Area e.g., puckering, pouting, smacking	0 1 2 3 4	0 1 2 3 4
Jaw e.g., biting, clenching, chewing, mouth opening, lateral movement	0 1 2 3 4	0 1 2 3 4
Tongue Rate only increase in movement both in and out of mouth, inability to sustain movement	0 1 2 3 4	0 1 2 3 4
Upper (arms, wrists, hands, fingers) Include choriec movements, (i.e., slow, irregular, complex, serpentine). Do not include tremor (i.e., repetitive regular, rhythmic).	0 1 2 3 4	0 1 2 3 4
Lower (*legs, knees, ankles, toes*) e.g. lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot	0 1 2 3 4	0 1 2 3 4
Neck, shoulder, hips e.g., rocking, twisting, squirming, pelvic gyrations	0 1 2 3 4	0 1 2 3 4
Severity of abnormal movements	0 1 2 3 4	0 1 2 3 4
Incapacitation due to abnormal movements	0 1 2 3 4	0 1 2 3 4
Patients awareness of abnormal movements Rate only patient's report	No Awareness 0 Aware, No Distress 1 Aware, Mild Distress 2 Aware, Moderate distress 3 Aware, severe distress 4	No Awareness 0 Aware, No Distress 1 Aware, Mild Distress 2 Aware, Moderate distress 3 Aware, severe distress 4
Current problems with teeth and/or dentures	No 0 Yes 1	No 0 Yes 1
Does patient usually wear dentures?	No 0 Yes 1	No 0 Yes 1

Total:_____ Total:_____

Staff Signature:_____ Date:_____

Staff Signature:_____ Date:_____

Examination Procedures

Either before or after completing the Examination Procedure, observe the client unobtrusively, at rest.

The Chair to be used in this examination should be a hard, firm one without arms.

---

1. Ask client whether there is anything in his/her mouth (i.e., gum, candy, etc.) and if there is, to remove it.

2. Ask client about current condition of his/her teeth. Ask client if he/she wears dentures. Do teeth or dentures bother client now?

3. Ask client whether he/she notices any movements in mouth, face, hands or feet. If yes, ask to describe and to what extent they currently bother client or interfere with his/her activities.

4. Have client sit in chair with hands on knees, legs slightly apart, and feet flat on the floor. Look at entire body for movements while in this position.

5. Ask client to sit with hands hanging unsupported. If male, between legs, if female and wearing a dress, hanging over knees. Observe hands and other body areas.

6. Ask client to open mouth. Observe abnormalities of tongue movement. Do this twice.

7. Ask client to protrude tongue. Observe abnormalities of tongue movement. Do this twice.

8. Ask client to tap thumb with each finger as rapidly as possible to 10-15 seconds, separately with right hand, then with left hand. Observe facial and leg movements.

9. Flex and extend client's left and right arms, one at a time. Note any rigidity.

10. Ask client to stand up. Observe in profile. Observe all body areas again, hips included.

11. Ask client to extend both arms outstretched in front with palms down. Observe trunk, legs and mouth.

    Have client walk a few spaces, turn and walk back to chair. Observe hands and gait. Do this twice.

VITAL SIGNS WEIGHT/HEIGHT RECORD
(Optional Form)

WHEN: When indicated or when M.D. issues an order

ON WHOM: Any appropriate client

COMPLETED BY: M.D., R.N., L.V.N.,

MODE OF COMPLETION: Legibly handwritten, typed or word processed on form HHSA:MHS-909

REQUIRED ELEMENTS: Note date and time of entry and complete as appropriate for client. Temperature, pulse, respiration's, weight, height, and blood pressure are to be entered if they are taken. Signature and title of staff completing documentation must be present.

Date	Time	Temp.	Pulse	Resp.	Wt.	Ht.	Blood Pressure	Signature & Classification

County of San Diego
Health and Human Services Agency
Mental Health Services

VITAL SIGNS/WEIGHT/HEIGHT RECORD

HHSA:MHS-909 (6/2003)

Client:______________________________

MR/Client ID #:______________________________

Program:______________________________

ADMINISTRATIVE/LEGAL

AGREEMENT FOR SERVICES

WHEN: First Face to Face Contact

ON WHOM: All Clients

COMPLETED BY: Client and the staff member registering the client.

MODE OF COMPLETION: Legibly handwritten on form HHSA:MHS-119.

REQUIRED ELEMENTS: All

BILLING: N/A

I, _____ agree to accept clinical treatment at
Client's Name

_____
Name of Clinic

The clinical treatment will include, but may not be limited to: intake assessments, designations of a primary therapist, as well as individual therapy, and medication monitoring. Psychiatric evaluation and medications are also available as needed. Signing this document implies agreement to all sections of the contract including sections on appointments, confidentiality, fee (if any), and rules and regulations.

CONTRACT GUIDELINES FOR SERVICES

1. Appointments: Your appointment time is specifically reserved for you. Because your appointment is reserved only for you, it is *necessary* that you not miss any appointments. Please *call at least 24 hours in advance to cancel appointments. If you miss more than two appointments, it will be discussed with you and your therapist, or doctor, and could mean that you will be discharged from the clinic. Remember, both your time and your therapist's time are very important.*

2. Length of treatment at the clinic may be limited and may consist of as few as 1-8 visits. Please discuss your expectations with your therapist and come to a preliminary agreement.

3. Confidentiality: All patients are assured of confidentiality in psychotherapy. A release of information form signed by you may authorize us to discuss any information with other individuals, and this agreement may be revoked by you at any time. There are some exceptions to confidentiality including:

    a. The law requires that we notify the potential victim if we judge that a client has the intention to harm another individual.

    b. We are required by law to report any suspected child abuse, neglect, or molestation to protect minors. Similarly, we are required to report suspected cases of elder abuse.

    c. If we judge the client to be seriously suicidal or unable to care for himself, we are obliged to notify the authorities to arrange for hospitalization.

    d. When you use health insurance to pay for psychotherapy, you may have to waive your confidentiality between insurance companies, officials, and your therapist.

I have read, understand and agree to accept treatment at the above named Clinic.

_____ _____
Client Signature Today's Date

_____ _____
Witness Today's Date

Advance Directive

Place Card

If the client has an Advance Directive, it should be filed here.

CLIENT QUESTIONNAIRE

WHEN: Beginning of treatment

ON WHOM: All Clients

COMPLETED BY: Client

MODE OF COMPLETION: Legibly handwritten on form HHSA:MHS-916

REQUIRED ELEMENTS: All

1. Name: _____
   * Last First Middle
2. Other Names that you have used: _____
   *Last First Middle
3. Birth Date _____
   *Month/Day/Year
4. Where you were born: _____
   *State or Country if not in USA
5. Driver's license Number: _____
6. Social security number: _____
7. Race
   ☐ White ☐ Black ☐ Native American/Eskimo/Aleut
   ☐ Chinese ☐ Japanese ☐ Filipino
   ☐ Indo-Chinese (Vietnamese, Cambodian, Laotian)
   ☐ Other ☐ Unknown
8. Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unknown
9. Sex ☐ Male ☐ Female
10. Maiden name: _____
    Last First Middle
11. Mother's maiden name _____
    Last First Middle
12. Mother's birth date _____
    Month/Date/Year
13. Marital Status
    ☐ Never Married ☐ Now Married, Remarried, Living Together
    ☐ Widowed ☐ Divorced (Includes Dissolution and Annulment)
    ☐ Separated ☐ Unknown
14. Spouses Name: _____
    Last First Middle
15. Spouse's birth date _____
    Month/Date/Year
16. Is anyone else in your family receiving County mental Health Services? ☐ Yes ☐ No
    If yes, what are their names? _____
    Last First Middle
    _____
    Last First Middle
17. With whom do you live?
    ☐ Lives alone in house or apartment
    ☐ Lives with Immediate Family (i.e. spouse, parents, children)
    ☐ Lives with extended family (i.e., relatives)
    ☐ Lives with non-related persons except for foster care
    ☐ Foster care home – children
    ☐ Small community care facility (6 or less)
    ☐ Large community care facility (7 or more)
    ☐ SNF/ICF
    ☐ Community Hospital or Psychiatric Health Facility
    ☐ State Hospital
    ☐ Justice related (Juvenile Hall, Community Correctional Facility, CYA Home)
    ☐ Group Quarter (Dorm, barracks, migrant camp, etc.)
    ☐ No identifiable residence
    ☐ Other
    ☐ Unknown

18. Address: _____
*Number and Street

_____
*City State Zip

19. Home phone number: (____) _____

20. Nearest Relative: _____
*Last First Middle

21. Relationship to you: _____

22. Relatives Address: _____
Number and Street

_____
*City State Zip

23. Your preferred primary language:
☐ English ☐ Spanish ☐ Chinese
☐ Japanese ☐ Korean ☐ Vietnamese
☐ Tagalog ☐ Sign Language ☐ Other

24. Where were you referred from? _____

25. Employment status:
☐ Full time, 35 hours or more weekly (competitive job market)
☐ Part time, less than 35 hours a week (competitive job market)
☐ Full time, 35 hours or more weekly (non-competitive job market)
☐ Part time, less than 35 hours a week (non-competitive job market)
☐ Unemployed
☐ Not in labor force (homemaker, student, retired, etc.)
☐ Unknown

26. Employer: _____

27. Employer's phone number: (____) _____

28. Check and circle the highest level of education:
☐ Elementary K 1 2 3 4 5 6 7 8 ☐ High School 9 10 11 12
☐ College 1 2 3 4 ☐ Graduate School 1 2 3 4 (or more)
☐ Other ☐ Unknown

29. Disability
☐ None ☐ Speech Impairment
☐ Blindness or Severe Visual Impairment ☐ Physical Impairment – Mobility Related
☐ Deaf or Severe Hearing Impairment ☐ Unknown

30. Who is financially responsible for this bill? _____
*Last Name First Middle

31. Address _____
*Number and Street

_____
*City State Zip

32. Employer _____

33. What is your insurance company ☐ _____ ☐ Medi-Cal ☐ Medicare

34. Are you carrying a weapon such as a gun or knife ☐ Yes ☐ No

35. Do you receive Veterans benefits? ☐ Yes ☐ No

For office use only* _____
Care Coordinator _____
UMDAP _____
Yearly Liability _____
Renewal Date _____
Financial Classification _____

CORRESPONDENCE

PREVIOUS TREATMENT

APPENDIX

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

WHEN: When clients desire disclosure of information.

ON WHOM: Clients wishing disclosure of medical records.

COMPLETED BY: Client or his or her legal representative and signed by client. Reference HHSA-L9

MODE OF COMPLETION: Legibly handwritten on form 23-07 HHSA (0403)

REQUIRED ELEMENTS: All Fields

COUNTY OF SAN DIEGO

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below.

DATE:		
PATIENT/RESIDENT/CLIENT		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS	CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	SSN:	DATE OF BIRTH:
AKA'S:		
THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO MAKE THE DISCLOSURE.		
LAST NAME OR ENTITY:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS	CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	DATE:	
THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION.		
LAST NAME OR ENTITY:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS	CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	DATE:	
TREATMENT DATES:	PURPOSE OF REQUEST: ☐ AT THE REQUEST OF THE INDIVIDUAL.	

THE FOLLOWING INFORMATION IS TO BE DISCLOSED: (PLEASE CHECK)

- ☐ History and Physical Examination
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Medication Records
- ☐ Interpretation of images: x-rays, sonograms, etc.
- ☐ Laboratory results
- ☐ Dental records
- ☐ Psychiatric records including Consultations
- ☐ HIV/AIDS blood test results; any/all references to those results
- ☐ Physician Orders
- ☐ Pharmacy records
- ☐ Immunization Records
- ☐ Nursing Notes
- ☐ Billing records
- ☐ Drug/Alcohol Rehabilitation Records
- ☐ Complete Record
- ☐ Other *(Provide description)* _____

_____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Photocopy or Fax:

I agree that a photocopy or fax of this authorization will be as effective as the original.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____

If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed.

County of San Diego

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Client: _____

Record Number: _____

Program: _____

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section164.524.

I have right to receive a copy of this authorization. I would like a copy of this authorization.
☐ Yes ☐ No

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE	
SIGNATURE:	DATE:
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP OF INDIVIDUAL:	

FOR OFFICE USE

VALIDATION	
SIGNATURE OF STAFF PERSON VALIDATING INFORMATION:	DATE:
SIGNATURE OF HEALTH CARE PROVIDER*:	DATE:

CONDADO DE SAN DIEGO

AUTORIZACIÓN PARA USAR O DIVULGAR LA INFORMACIÓN PROTEGIDA DE SALUD

Por medio de este documento, autorizo el uso o divulgación de la información de salud de la persona nombrada según se describe abajo.

		FECHA:
PACIENTE / RESIDENTE / CLIENTE		
APELLIDO:	PRIMER NOMBRE:	INICIAL SEGUNDO NOMBRE:
DIRECCIÓN	CIUDAD/ESTADO:	CÓDIGO POSTAL:
NÚMERO TELEFÓNICO:	Nº DE SEGURO SOCIAL:	FECHA DE NACIMIENTO:
SEUDÓNIMO:		
LA SIGUIENTE PERSONA U ORGANIZACIÓN ESTÁ AUTORIZADA PARA HACER LA DIVULGACIÓN.		
APELLIDO O ENTIDAD:	PRIMER NOMBRE:	INICIAL SEGUNDO NOMBRE:
DIRECCIÓN	CIUDAD / ESTADO:	CÓDIGO POSTAL:
NÚMERO TELEFÓNICO:	FECHA:	
ESTA INFORMACIÓN SE PUEDE DIVULGAR Y USAR POR LA SIGUIENTE PERSONA U ORGANIZACIÓN.		
APELLIDO O ENTIDAD:	PRIMER NOMBRE:	INICIAL SEGUNDO NOMBRE:
DIRECCIÓN	CIUDAD / ESTADO:	CÓDIGO POSTAL:
NÚMERO TELEFÓNICO:	FECHA:	
FECHAS DE TRATAMIENTO:	PROPÓSITO DE LA SOLICITUD: ☐ A la SOLICITUD DE LA PERSONA.	

SE DEBE REVELAR LA SIGUIENTE INFORMACIÓN: (SÍRVASE MARCAR)

- ☐ Historia y examen físico
- ☐ Resumen de alta
- ☐ Notas de mejoramiento
- ☐ Expedientes de medicamentos
- ☐ Interpretación de imágenes: radiografías, sonogramas, etc.
- ☐ Expedientes de laboratorio
- ☐ Expedientes dentales
- ☐ Expedientes psiquiátricos incluyendo consultas
- ☐ Resultados de pruebas de sangre VIH/SIDA, toda referencia de estos resultados
- ☐ Órdenes del médico
- ☐ Expedientes de farmacia
- ☐ Expedientes de inmunización
- ☐ Notas de enfermería
- ☐ Expedientes de facturación
- ☐ Expedientes de rehabilitación de alcohol/ drogas
- ☐ Expediente completo
- ☐ Otro (*Describa*) _____

Información delicada Tengo entendido que la información en mi expediente puede incluir información relacionada con las enfermedades de transmisión sexual, síndrome de inmunodeficiencia adquirida (SIDA) o infección con el virus de inmunodeficiencia humana (VIH). Asi mismo puede incluir información sobre los servicios de comportamiento o salud mental o tratamiento para abuso de alcohol y drogas.

Derecho a revocar: Tengo entendido que tengo derecho a revocar esta autorización en cualquier momento. Tengo entendido que si revoco esta autorización debo hacerlo por escrito. Tengo entendido que la revocación no se aplica a la información que ya ha sido divulgada basada en esta autorización.

Fotocopia o Fax
Estoy de acuerdo en que una fotocopia o fax de esta autorización sea considerado tan efectivo como el original.

Vencimiento A menos que se revoque de otro modo, esta autorización vencerá en la siguiente fecha, evento o condición:

_____

Si no especifico una fecha, evento o condición de vencimiento, esta autorización vencerá en un (1) año calendario a partir de la fecha en que se firmó.

Redivulgación: Si he autorizado la divulgación de información sobre mi salud a alguien a quien no se le exige legalmente mantenerla confidencial, tengo entendido que puede ser redivulgada y ya no estar protegida. Las leyes de California generalmente prohiben a los destinatarios de mi información de salud sobre la redivulgación de dicha información excepto con mi autorización o según se exija específicamente o se permita por ley.

Otros derechos: Tengo entendido que la autorización para divulgar esta información de salud es voluntaria. Puedo rehusarme a firmar esta autorización. No necesito firmar este formulario para asegurar el tratamiento. Sin embargo, si esta autorización es necesaria para la participación en un estudio de investigación, se puede denegar mi inscripción en el estudio de investigación.

Tengo entendido que puedo revisar u obtener una copia de la información que se usará o divulgará según se estipula en la sección 164.524 del código 45 de las regulaciones federales.

Tengo derecho de recibir una copia de esta autorización. Desearía una copia de esta autorización.

☐ Sí ☐ No

FIRMA DE PERSONA O REPRESENTANTE LEGAL

FIRMA:	FECHA:

SI FIRMA EL REPRESENTANTE LEGAL, PARENTESCO CON LA PERSONA:

PARA USO OFICIAL	**IDENTIFICACIÓN RATIFICADA**
FIRMA DE MIEMBRO DEL PERSONAL:	FECHA:

FIRMA DEL PROVEEDOR DEL CUIDADO MÉDICO *:	FECHA:

* El Proveedor del cuidado médico que aprueba al cliente acceso a sus propios expedientes.

SAN D/MAP PROGRAMS

SAN D/MAP PROGRAMS

1. Client Self-Report

2. Clinician Symptom Rating

CLIENT SELF-REPORT

WHEN: At every physician appointment

ON WHOM: All Clients

COMPLETED BY: Client

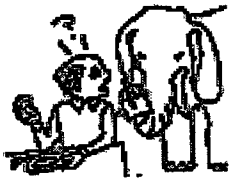
MODE OF COMPLETION: Legibly Handwritten.

REQUIRED ELEMENTS: All

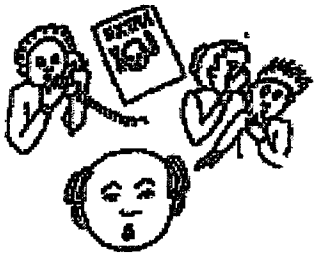
Schizophrenia

SYMPTOMS

Jumping from one subject to another and saying things that don't make sense

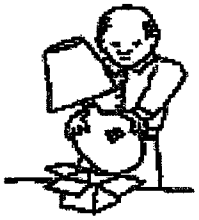


Seeing, hearing, or feeling things that other do not



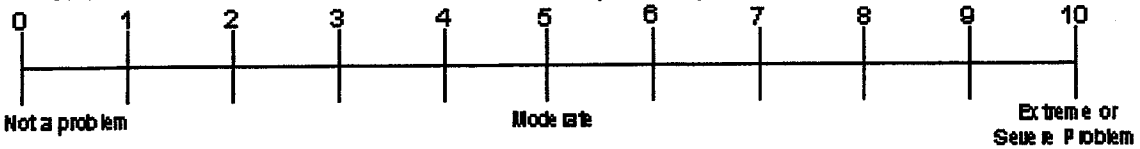
False Beliefs or thoughts that no one believes or understands (for example, believing others are always talking about you)

No interest or feelings about anything



Unable to complete everyday tasks

Circle the number that best describes how much a problem your symptoms were:



List the most bothersome symptoms in the last week:

- _____
- _____
- _____

Things I did for me: _____

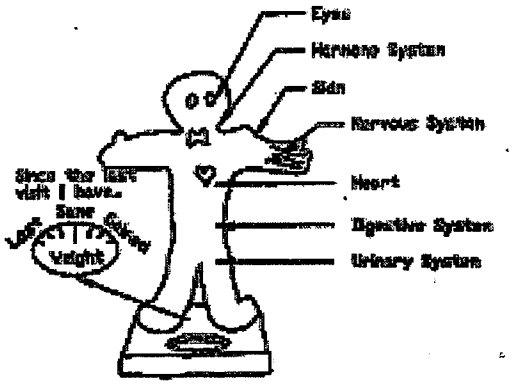
_____

_____

Schizophrenia

Side Effect

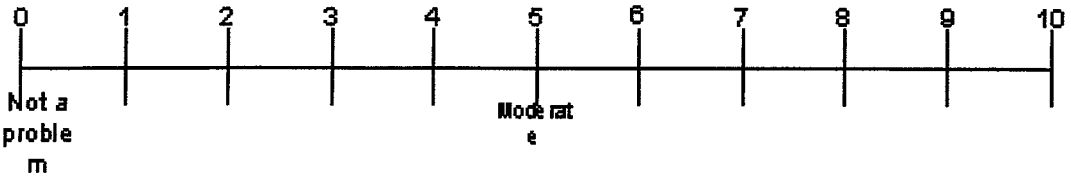
Medications can cause side effects in many parts of the body. Some may go away in time, others can be treated by your doctor.



Ask your doctor about side effects that need to be reported immediately!

Illegal drugs and alcohol may increase the side effects of medications or keep them from working

Circle the number that best describes how much a problem your side effects were:



List the most bothersome side effects in the last week:

- _____
- _____
- _____

Things I did for me: _____

_____

_____

List medications that you are currently taking:

1. _____
2. _____
3. _____
4. _____

About how long have you been taking each medication? Weeks Months Years

CLINICIAN SYMPTOM RATING

WHEN: At each visit.

ON WHOM: SanDMAP Health patients enrolled in the Schizophrenia Algorithm.

COMPLETED BY: Mental Health Provider trained to conduct Brief Psychiatric Rating Scale.

MODE OF COMPLETION: Legibly handwritten or typed on form HHSA:MHS-918.

REQUIRED ELEMENTS: All items must be completed.

BILLING: Document time spent on form. To calculate total number of minutes include preparation time, interview time, and *documentation time.* ***Also*** *note the number of minutes spent solely as face-to-face time (direct time).*
For Example: Total: 120 Minutes
Direct: 60 Minutes

Interviewer: _____
(Printed Name)

Visit#: _____

BRIEF PSYCHIATRIC RATING SCALE

NA	1	2	3	4	5	6	7
Not assessed	Not present	Very mild	Mild	Moderate	Moderately severe	Severe	Extremely severe

Rate items on the basis of patient's self-report during interview. Item 2 is also rated on observed behavior during interview. Item 4 is rated on the basis of observed behavior and speech.

BRIEF POSITIVE SYMPTOMS (PSRS)

1.	Suspiciousness	NA	1	2	3	4	5	6	7	
2.	Unusual thought content	NA	1	2	3	4	5	6	7	
3.	Hallucinations	NA	1	2	3	4	5	6	7	
4.	Conceptual disorganization	NA	1	2	3	4	5	6	7	Score_____

BRIEF NEGATIVE SYMPTOMS (BNSA)

1.	Prolonged time to respond	1	2	3	4	5	6	
2.	Emotion: unchanging facial expressions; Blank, expressionless face	1	2	3	4	5	6	
3.	Reduced social drive	1	2	3	4	5	6	
4.	Grooming and hygiene	1	2	3	4	5	6	Score_____

Sources of information (check all applicable):

_____Patient
_____Parents/Relatives
_____Mental Health Professionals
_____Chart

Explain here if validity of assessment is questionable:

_____Symptom possibly drug-induced
_____Under-reported due to lack of rapport
_____Under-reported due to negative symptoms
_____Patient uncooperative
_____Difficult to assess due to formal thought disorder
_____Other:_____

Confidence in assessment:

_____1 = Not at all; 5 = Very confident

Administration as per Care Coordinator Check List.

GLOBAL AIMS: ☐ 0 = None ☐ 1 = Minimal, may be extreme normal ☐ 2 = Mild ☐ 3 = Moderate ☐ 4 = Severe

Completed by: _____ _____ _____ _____
Signature | Title | Date | Time Spent

County of San Diego
Health and Human Services Agency
Mental Health Services

CLINICIAN SYMPTOM RATING

HHSA:MHS-918 (07/2004)

Client#:_____

MR/Client #:_____

Program:_____

CASE MANAGEMENT

CASE MANAGEMENT FILE CHART ORDER

INSIDE OF LEFT COVER:
Written Face Sheets
Dangerous Propensities
Medi-Cal/Medicare/Green Cards in plastic sleeve or envelope

INSIDE RIGHT (ON TOP OF PATIENT DATA TAB):
Client Checklist
C.M. File Chart Order

RIGHT SIDE OF FILE CHART: Title/Contents

1. Patient Data
1.1 Client Information Face Sheet (INSYST)-current
1.2 Client/Service Info (CSI) Update
1.3 Episode Opening/Closing (Pink Sheet)
1.4 Utilization Review Committee Record

2. Assessment
2.1 Community Function Evaluation
2.2 Conservatorship Investigation Report
2.2 Conservatorship Statement of Facts
2.3 Forensics Evaluation
2.4 Initial Assessment
2.4 Old Initial Assessments
2.5 Referral Form
2.6 Psychological Testing

3. Treatment Plan
3.1 Client Plans
3.2 Crisis Plans

4. Progress Notes
4.1 Progress Notes
4.2 Six-month Review & Progress Note
4.3 Transfer/Discharge/Admission Summary & Checklist

5. Medical
5.1 Diagnosis Confirmation Letter
5.2 Lab Test
5.3 Medical History Questionnaire
5.4 Other Medical Reports/Dental, etc.

6. Legal
6.1 All Legal Documents from the Court
6.2 Court Grams
6.3 LPS Re-establishment (blue sheet)
6.4 Medical Rec. & Declaration for Re-establishment of Conservatorship

7. Administrative
7.1 Advisement (pre-HIPAA)
7.2 Agreement for Services
7.3 Consent for Involvement of Interested Parties
7.4 Financial Agreement
7.5 Medi-Cal Documents
7.6 Medicare Notices (last 3 years)
7.7 Notice of Privacy Practices Receipt
7.8 Property Storage Agreement
7.9 Release of Information (HIPPA)
7.10 SSA 07-94
7.11 SSA-II-Bk (Request to be payee)
7.12 SSA/SSI Applications & Re-determinations
7.13 Trusts
7.14 VA Documents

8. Financial
8.1 08-46 (Instructions to Sub. Payee)
8.2 Bills/Receipts
8.3 Client Pay Stubs
8.4 Subpayee Ledgers

9. Correspondence
9.1 Interoffice Memos
9.2 Received/Sent Letters

10. Miscellaneous
Augmented Services Scoring Tool
Authorization for Medi-Cal Day Tx
Birth Certificates
IMD Discharge Summary
Prior Record
Records from Other Sources
Renter's Agreements
Renter's Assistance
Service Requests

Not to be filed in chart:
Morning Report
Peer Review Checklist
Serious Incident Report
Voters' Registration

CASE MANAGEMENT- AGREEMENT FOR SERVICES

WHEN: On admission

ON WHOM: Voluntary clients accepting Case Management Services from County or Contracted Case Management Programs or;

Clients on conservatorship that may accept voluntary services. *

COMPLETED BY: Case Management staff at County and Contracted Case Management Programs and/or Case Management Conservators sign on behalf of conservatees.

MODE OF COMPLETION: Legibly handwritten, form HHSA:MHS-864

REQUIRED ELEMENTS: All elements must be completed

NOTE: This form replaces the Mental Health Services Request for Outpatient Services form (HHSA:MHS-050s)

- For conservatees who are unwilling to sign, the Case Manager will reference LPS Conservatorship papers

I, _____ agree to accept treatment and Case
Client's Name Management services at

_____
Name of Clinic/Program

The treatment and case management services will include, but not be limited to: assessments, designations of a primary case manager or case management team, as well as individual visits, and advocacy. Signing this document implies agreement to all sections below:

CONTRACT GUIDELINES FOR SERVICES

1. **Appointments:** Your appointment time is specifically reserved for you. Because your appointment is reserved only for you, it is requested that you call at least 24 hours in advance to cancel appointments. *Remember, both your time and your case manager's time are very important.*

2. **Length of treatment** is based on a set of established criteria for Case Management services as well as your individual needs. Please discuss your expectations with your case manager and come to a preliminary agreement.

3. **Confidentiality:** All clients are assured of confidentiality while working with Case Management. A release of information form signed by you may authorize us to discuss any information with other individuals, and this agreement may be revoked by you at any time. There are some exceptions to confidentiality including:
   a. The law requires that we notify the potential victim if we judge that a client has the intention to harm another individual.

   b. We are required by law to report any suspected child abuse, neglect, or molestation to protect minors. Similarly, we are required to report suspected cases of elder abuse.

   c. If we judge the client to be seriously suicidal or unable to care for himself, we are obliged to notify the authorities to arrange for hospitalization.

I have read, understand and agree to accept treatment at the above named Clinic/ Program.

_____ _____
Client Signature Today's Date

_____ _____
Witness Today's Date

_____
Staff: Note here reason unsigned, if applicable.

County of San Diego
Health and Human Services Agency
Mental Health Services
Case Management Services

CASE MANAGEMENT – AGREEMENT FOR SERVICES
HHSA:MHS-864 (6/29/2003)

Client: _____

MR/Client ID #: _____

Program: _____

CASE MANAGEMENT- CLIENT FINANCIAL INFORMATION

WHEN: Upon admission to services.

ON WHOM: Clients receiving case management services from County or Contracted Case Management Programs

COMPLETED BY: Individual registering client.

MODE OF COMPLETION: Legibly handwritten, on form HHSA:MHS-862

REQUIRED ELEMENTS: All elements should be completed.

Client Financial Information

Case Management is a reimbursable service.

This applies to the initial screening or intake as well as other times.

_____

Name of Clinic/Program

will bill your insurance company for services provided to you. Your health Insurance may cover part or the entire cost of care provided by this service. It is important that you notify staff on enrollment of your insurance coverage. We would also like to receive a copy of your insurance card.

This agreement allows for the release of medical information necessary to process claims.

It is important to notify staff of any changes to your insurance coverage.

Client:_____ Date: _____

Client's Agent or Representative: _____ Date: _____

Relationship to Client: _____

Witness: _____ Date: _____

CASE MANAGEMENT- DISCHARGE SUMMARY

WHEN: This form must be completed at the time of discharge for clients open to Case Management Services.

ON WHOM: Clients discharged or transferred from Case Management Services from County or Contracted Case Management Programs or:

Clients that have not received services for three months unless the case manager has documented need to keep case open.

COMPLETED BY: Case Management staff at County and Contracted Case Management Programs

MODE OF COMPLETION: Legibly handwritten, typed or word-processed on form HHSA:MHS-860.

REQUIRED ELEMENTS: All elements should be completed.

BILLING: Same as adult chart.

NOTE: This form accompanies the CASE MANAGEMENT-TRANSFER/CASE MANAGER DISCHARGE CHECKLIST form (HHSA-MHS-863).

Date of Admission: _____ Discharge Date: _____

Payee: _____

Diagnosis at Discharge – DSM IV

		Code
Axis I:	_____	_____
	_____	_____
Axis II:	_____	_____
Axis III:	_____	_____
Axis IV:	_____	_____
Axis V:	_____	_____

*** CAUTIONS/DANGERS/ALLERGIES *** _____

_____

Reason for Admission: (Presenting Problem) _____

_____

_____

Reason for Termination: _____

_____

_____

Assessment Results; Course of Treatment/Services and Response to Treatment/Services: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

County of San Diego
Health and Human Services Agency
Mental Health Services
Case Management Services

CASE MANAGEMENT – DISCHARGE SUMMARY

HHSA:MHS-860 (6/2002)

Client: _____

MR/Client ID #: _____

Program: _____

Assessment Results; Course of Treatment/Services and Response to Treatment/Services: _____

Services/Treatment Complete ☐ Yes ☐ No

History or Propensity for Violence, Fire setting, Criminal Activity, Sex Offences, or Suicide Attempts: _____

Discharge Medication: (Name/dose/frequency if known) _____

Prognosis: (poor, fair, guarded, good (Brief description of current level of functioning) _____

Discharge Plan/recommendation/disposition: (Aftercare plan, living arrangements) _____

Referred to: _____ **Appointment Date:** _____ **Time:** _____

Signature

Clinician: _____ **Date:** _____

CASE MANAGEMENT – FACE SHEET

WHEN: On admission and update as necessary to provide data for use in planning services.

ON WHOM: Clients receiving case management services from County or Contracted Case Management Programs.

COMPLETED BY: Case Management staff at County and Contracted Case Management Programs.

MODE OF COMPLETION: Legibly handwritten, typed or word-processed on forms HHSA:MHS-861.

REQUIRED ELEMENTS: As appropriate, all elements should be completed.

NOTE: This form may be filed in the front of the Clinical Record Manual.

☐ Closed

Last Name	First Name	MI	Aka/Maiden Name	Sex	Race

D.O.B.	Birthplace	Marital Status	Language	Height	Weight	Eyes	Hair

Distinguishing Marks	Date Opened	Annual Review Date

Program	Case Manager	Social Security Number

Current Address	See Placement History Page	☐ Maintenance ☐ Conservatorship

Axis I & II Diagnosis (and source):

_____

_____

_____

Dangerous Propensity/Substance Abuse:

_____

_____

_____

SERVICE PROVIDERS

Service Providers (MD, Day, Tx, etc.)	Name/ Agency	Street	City	State	Zip Code	Area Code	Phone	Start Date

PERSONAL CONTACTS

Relation	Name	Street	City	State	Zip Code	Area Code	Phone

Source	Amount	Eligible
TOTAL		

Other Resources

☐ Medi-Cal #_____

☐ Medicare #_____

☐ VA _____

☐ Other _____

☐ Other _____

☐ Other Ins _____

PAYEE:

PLACEMENT INFORMATION

Enter Date	Exit Date	Placement	Street	City	State	Zip Code	Area Code	Phone	Hosp

CASE MANAGEMENT- TRANSFER/CASE MANAGER DISCHARGE CHECKLIST

WHEN: On discharge from Case Management Services or when client is transferred to another case management program or service.

ON WHOM: Clients receiving case management services from County or Contracted Case Management Programs

COMPLETED BY: Case Management staff at County and Contracted Case Management Programs

MODE OF COMPLETION: Legibly handwritten, typed or word-processed on form HHSA:MHS-863

REQUIRED ELEMENTS: All elements should be completed.

NOTE: This form accompanies the CASE MANAGEMENT- DISCHARGE SUMMARY form (HHSA-MHS-860)

☐ Face-to-Face Visit in past 30 days/date of last visit: _____

☐ Face sheet and addendum complete/current

☐ Clinical Record Forms

- ☐ Insyst Episode and face sheet (MHS-800) ☐ Dangerous Propensity Form
- ☐ Assessment ☐ Discharge Summary
- ☐ Client Plan ☐ Conservatorship papers, letters, and Orders
- ☐ Community Functioning Evaluation ☐ Investigative Reports
- ☐ Medical History Questionnaire
- ☐ Other: _____

☐ Subpayee status cleared

☐ Current master file

☐ Pending fiscal matters cleared/completed

☐ Change of worker on 08-46 sent to fiscal

☐ 07-94 reporting changes of address/placement level to SSA

☐ Level of Care Assessment

☐ Notifications (Documentation in Progress Notes)

☐ Board and Care Manager ☐ Psychiatric Services

☐ Client ☐ Significant others

☐ Receiving worker ☐ Public Guardian

☐ Court Unit (if on conservatorship)

Case being transferred to: _____
Name of new clinician/program

_____	_____	_____	_____
Clinician Signature	Date	Program Manager	Date

CO-OCCURRING DISORDERS
QUADRANT MODEL SUBGROUPING & PLANNING GUIDE

(Note: required form for CCISC Cadre participating programs)

WHEN: This form is to be completed in conjunction with Initial Mental Health Assessment (MHS 912), Expedited Assessment (MHS 991) or Mental Health Assessment Update (MHS 940).
Additionally, this form is to be completed at each Client Plan (MHS 975) update or rewrite, at the time of a planned discharge when Discharge Summary (MHS 920) is completed, or more often if clinically indicated.

ON WHOM: All clients who are being assessed for admission into a program, all existing clients at the time of their Client Plan update or rewrite, all clients at the time of a planned discharge.

COMPLETED BY: Staff delivering services within the scope of their practice at programs that are participating Cadre members of the Comprehensive, Continuous, Integrated System of Care (CCISC). Use of this form by programs other than Cadre members is optional.

MODE OF COMPLETION: Legibly handwritten, typed or word processed on form HHSA: MHS 955 Co-Occurring Disorders Quadrant Model Subgrouping & Planning Guide

REQUIRED ELEMENTS: Item #1, staff signature, title, and date are mandatory elements. If item #1 is "yes", completion of items #2, #3, and #4 are also required. Follow the accompanying "Co-Occurring Disorders Quadrant Model Sub-grouping and Planning Guide Instructions" for specific directions on completion of items #1 - #4.

BILLING: Billing for completing this form shall only occur when it is connected to a direct client service such as an assessment or an individual session for the purpose of client plan development or planned discharge.

Co-Occurring Disorders
Quadrant Model Sub-grouping & Planning Guide
Instructions

Overview:

The attached "Co-Occurring Disorders Quadrant Model Sub-Grouping & Planning Guide" was developed in order to assist mental health providers in the Adult/Older Adult Mental Health System (AOAMHS)identify which Quadrant and Stage of Change ***best*** reflects an individual with co-occurring disorders, according to the CCISC model.

The guide is not, in and of itself, a screening, assessment, or diagnostic tool. Instead, it was developed to be utilized as a way to identify, track, determine system responsibility, and stage of change for individuals with co-occurring mental health and substance disorders according to the CCISC model, as described in the County of San Diego, Charter and Consensus Document.

Instructions:
Do not use this guide as a screening, assessment, or diagnostic tool. Instead, use it as an addendum to the current County AOAMHS approved mental health assessment and other diagnostic screening and assessment tools and measures.

1. Answer yes/no if the client has a co-occurring mental health and substance disorder by placing a check in the space provided.
    a. If yes, continue.
    b. If no, check no and stop at this point.

2. Identify which Quadrant ***best*** reflects the individual at the time of completion of this form by placing a check in the appropriate quadrant. According to the Charter and Consensus Document:
    a. Alcohol & Drug Services will primarily be responsible for Quadrants I & III
    b. Adult/Older Adult Mental Health Services will primarily be responsible for Quadrants II & IV (IV.B.)

3. Identify which Stage of Change ***best*** reflects the client at the time of completion by placing a check in the appropriate boxes. Identify the Stage of Change for each disorder present. The treatment recommendations listed are only prompts, not specific services or service plans per se.

4. Fill in Recommendations for services for ***each*** disorder, which must be discussed with clients and the treatment team.

5. Complete form at admission, when completing/updating Service Plans as needed, at annual re-assessment, and at discharge if planned.

1. Co-Occurring Disorder? ___ YES ___ NO

(If YES, proceed with form. If NO, stop)

2. Quadrant Model (Minkoff, 2001; Ries, 1992)

(Place a check in the appropriate quadrant)

☐ **Quadrant I** **PSYCH = LOW** **SUBSTANCE = LOW** Mild psychopathology with Substance Abuse **Setting = Possible Link to ADS**	☐ **Quadrant II** **PSYCH = HIGH** **SUBSTANCE = LOW** Serious &/or Persistent Mental Illness (SPMI) with Substance Abuse **Setting = AMHS**
☐ **Quadrant III** **SUBSTANCE = HIGH** **PSYCH = LOW** Psychiatrically Complicated Substance Dependence **Setting = Link to ADS program**	☐ **Quadrant IV** **PSYCH = HIGH** **SUBSTANCE = HIGH** SPMI with Sub. Dependence/Poly Abuse Or Substance induced/exacerbated Psych. Disorders **Setting = AMHS & possible link to ADS.**

3. Stages of Change (Prochaska & DiClemente,) (Must identify stage for *each* condition)

Stage	Psych	Substance	Treatment Recommendation
Pre-Contemplation			Engagement, Motivational Interviewing (MI)
Contemplation			Engagement, MI
Preparation/Determination			MI, Plan Development
Action			Treatment, Skill Teaching
Maintenance			Skill Teaching, Ongoing Recovery
Relapse			Re-Assess, Treatment, Skill Teaching, Recovery

4. Recommendations: 1. _____

(For each disorder) 2. _____

3. _____

4. _____

Signature and Title: _____ **Date:** _____

Printed Name: _____